Considerations for Patients with Concurrent Asthma and COPD

Excerpts from GINA 2024 Strategy for Asthma Management and Prevention:

Asthma and COPD are umbrella labels for heterogeneous conditions characterized by chronic airway and/or lung disease. Asthma and COPD each include several different clinical phenotypes, and are likely to have several different underlying mechanisms, some of which may be common to both asthma and COPD.[1]

Box 7-2. Syndromic approach to initial treatment in patients with asthma and/or COPD

CLINICAL PHENOTYPE - ADULTS WITH CHRONIC RESPIRATORY SYMPTOMS (dyspnea, cough, chest tightness, wheeze)

HIGHLY LIKELY TO BE ASTHMA if several of the following features TREAT AS ASTHMA	FEATURES OF BOTH ASTHMA + COPD TREAT AS ASTHMA	LIKELY TO BE COPD if several of the following features TREAT AS COPD
HISTORY • Symptoms vary over time and in intensity - Triggers may include laughter, exercise, allergens, seasonal - Onset before age 40 years - Symptoms improve spontaneously or with bronchodilators (minutes) or ICS (days to weeks) • Current asthma diagnosis, or asthma diagnosis in childhood **LUNG FUNCTION** • Variable expiratory airflow limitation • Persistent airflow limitation may be present	**HISTORY** • Symptoms intermittent or episodic - May have started before or after age 40 • May have a history of smoking and/or other toxic exposures, or history of low birth weight or respiratory illness such as tuberculosis • Any of asthma features at left (e.g. common triggers; symptoms improve spontaneously or with bronchodilators or ICS; current asthma diagnosis or asthma diagnosis in childhood) **LUNG FUNCTION** • Persistent expiratory airflow limitation • With or without bronchodilator reversibility	**HISTORY** • Dyspnea persistent (most days) - Onset after age 40 years - Limitation of physical activity - May have been preceded by cough/sputum - Bronchodilator provides only limited relief • History of smoking and/or other toxic exposure, or history of low birth weight or respiratory illness such as tuberculosis • No past or current diagnosis of asthma **LUNG FUNCTION** • Persistent expiratory airflow limitation • With or without bronchodilator reversibility
INITIAL PHARMACOLOGICAL TREATMENT (as well as treating comorbidities and risk factors. See Box 3-12)		
• **ICS-CONTAINING TREATMENT IS ESSENTIAL to reduce risk of severe exacerbations and death.** - GINA Track 1 with ICS-formoterol as reliever is the preferred regimen. See Box 4-6 and Box 4-8 • **DO NOT GIVE LABA and/or LAMA without ICS** • Maintenance OCS only as last resort	• **ICS-CONTAINING TREATMENT IS ESSENTIAL to reduce risk of severe exacerbations and death.** • Add-on LABA and/or LAMA usually also needed • Additional COPD treatments as per GOLD • **DO NOT GIVE LABA and/or LAMA without ICS** • Maintenance OCS only as last resort	• **TREAT AS COPD (see GOLD report)** - Initially maintenance LABA-LAMA - Add ICS as per GOLD for patients with hospitalizations, ≥2 exacerbations/year requiring OCS, or blood eosinophils ≥300/µl • Avoid high dose ICS, avoid maintenance OCS • Reliever containing ICS is not recommended

REVIEW PATIENT AFTER 2-3 MONTHS. REFER FOR EXPERT ADVICE IF DIAGNOSTIC UNCERTAINTY OR INADEQUATE RESPONSE

'Asthma-COPD overlap' and 'asthma + COPD' are terms used to collectively describe patients who have persistent airflow limitation together with clinical features that are consistent with both asthma and COPD.

This is not a definition of a single disease entity, but a descriptive term for clinical use that includes several different clinical phenotypes reflecting different underlying mechanisms.

There is broad agreement that patients with features of both asthma and COPD have a greater burden of symptoms, experience frequent exacerbations, have poor quality of life, a more rapid decline in lung function, higher mortality, and greater use of healthcare resources compared with patients with asthma or COPD alone.[1]

Reference: 1. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2024. Updated May 2024. Available from: www.ginasthma.org

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