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# Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline Update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society

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## Abstract

**Description:** This guideline is an official statement of the American College of Physicians (ACP), American College of Chest Physicians (ACCP), American Thoracic Society (ATS), and European Respiratory Society (ERS). It represents an update of the 2007 ACP clinical practice guideline on diagnosis and management of stable chronic obstructive pulmonary disease (COPD) and is intended for clinicians who manage patients with COPD. This guideline addresses the value of history and physical examination for predicting airflow obstruction; the value of spirometry for screening or diagnosis of COPD; and COPD management strategies, specifically evaluation of various inhaled therapies (anticholinergics, long-acting β-agonists, and corticosteroids), pulmonary rehabilitation programs, and supplemental oxygen therapy.

**Methods:** This guideline is based on a targeted literature update from March 2007 to December 2009 to evaluate the evidence and update the 2007 ACP clinical practice guideline on diagnosis and management of stable COPD.

**Recommendation 1:** ACP, ACCP, ATS, and ERS recommend that spirometry should be obtained to diagnose airflow obstruction in patients with respiratory symptoms (Grade: strong recommendation, moderate-quality evidence). Spirometry should not be used to screen for airflow obstruction in individuals without respiratory symptoms (Grade: strong recommendation, moderate-quality evidence).

**Recommendation 2:** For stable COPD patients with respiratory symptoms and $FEV_1$ between 60% and 80% predicted, ACP, ACCP, ATS, and ERS suggest that treatment with inhaled bronchodilators may be used (Grade: weak recommendation, low-quality evidence).

**Recommendation 3:** For stable COPD patients with respiratory symptoms and $FEV_1$ <60% predicted, ACP, ACCP, ATS, and ERS recommend treatment with inhaled bronchodilators (Grade: strong recommendation, moderate-quality evidence).

**Recommendation 4:** ACP, ACCP, ATS, and ERS recommend that clinicians prescribe monotherapy using either long-acting inhaled anticholinergics or long-acting inhaled β-agonists for symptomatic patients with COPD and $FEV_1$ <60% predicted. (Grade: strong recommendation, moderate-quality evidence). Clinicians should base the choice of specific monotherapy on patient preference, cost, and adverse effect profile.

**Recommendation 5:** ACP, ACCP, ATS, and ERS suggest that clinicians may administer combination inhaled therapies (long-acting inhaled anticholinergics, long-acting inhaled β-agonists, or inhaled corticosteroids) for symptomatic patients with stable COPD and $FEV_1$<60% predicted (Grade: weak recommendation, moderate-quality evidence).

**Recommendation 6:** ACP, ACCP, ATS, and ERS recommend that clinicians should prescribe pulmonary rehabilitation for symptomatic patients with an $FEV_1$ <50% predicted (Grade: strong recommendation, moderate-quality evidence). Clinicians may consider pulmonary rehabilitation for symptomatic or exercise-limited patients with an $FEV_1$ >50% predicted. (Grade: weak recommendation, moderate-quality evidence).

**Recommendation 7:** ACP, ACCP, ATS, and ERS recommend that clinicians should prescribe continuous oxygen therapy in patients with COPD who have severe resting hypoxemia ($PaO_2$ ≤55 mm Hg or $SpO_2$ ≤88%) (Grade: strong recommendation, moderate-quality evidence).

## Related articles

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Ann Intern Med January 3, 2012 156:68-69;