

COPD-X Checklist

Diagnosis and Management of COPD

C – Confirm diagnosis

Presence and history of symptoms:

- Shortness of breath
- Cough
- Sputum production

Smoking – history and willingness to quit:

- Smoker Pack years
- Willingness to quit high medium low
- Previous Smoker
- Non-smoker
- Other smoking-related disease

Anyone who smokes and /or has shortness of breath and sputum production could have COPD.

Spirometry – measure FEV₁ and FEV₁/FVC and assess reversibility of airflow limitation

Spirometry is essential for case-finding, to differentiate between asthma and COPD, and to determine the degree of disease severity.

Grade COPD severity:

Based on spirometry results – FEV₁ % of predicted post-bronchodilator.

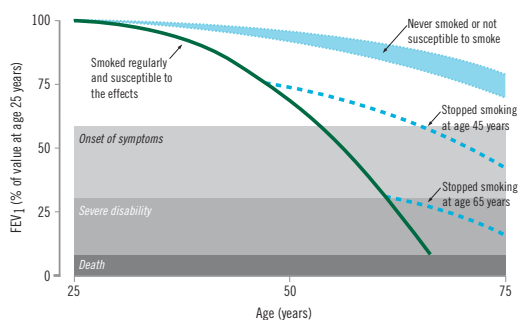
- 60-80% = Mild
- 40-59% = Moderate
- <40% = Severe

	Pre-bronchodilator	% pred	Post-bronchodilator	Reversibility* (%)
FEV ₁				
FVC				
FEV ₁ /FVC				

COPD is defined as post-bronchodilator FEV₁/FVC <0.70 and FEV₁ <80% predicted. If fully reversible (to normal values) treat as asthma.

$$\text{*Reversibility} = \frac{(\text{FEV}_1 \text{ post BD}) - (\text{FEV}_1 \text{ pre BD})}{\text{FEV}_1 \text{ pre BD}} \times 100$$

Smoking Effects on Symptoms & Life Expectancy



Adapted from Fletcher C, Peto R. The natural history of chronic airflow obstruction. BMJ 1977;1:1645-1648 and reproduced with permission from the BMJ Publishing Group.

O – Optimise function

- Check smoking status
- Query optimal drug therapy
- Check compliance
- Review exercise status
- Check current device use
- Nutrition
- Consider sleep apnoea



Go to:

*www.pulmonaryrehab.com.au
for information on setting up a
pulmonary rehabilitation program.*

This checklist is based on the evidence-based consensus document, the COPD-X Plan, Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease 2003. This is an independent joint project of the Thoracic Society of Australia and New Zealand and The Australian Lung Foundation, contributed to by physicians, general practitioners, nurses and allied health professionals. See - MJA 2003; 178(Suppl).

The COPD-X Guidelines are updated regularly. Visit www.copdx.org.au for the most up-to-date version.

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*Visit the COPD-X reference website
for up-to-date information on
management & treatment of COPD
www.copdx.org.au*

P – Prevent deterioration

Essential Steps:

- Annual influenza vaccination
- Pneumococcal vaccination
- Consider long-term home oxygen

Risk factor reduction:

- Check current smoking status
- Advise of the risks of smoking and benefits of stopping
- Refer to a Quit program if appropriate - Quitline 131 848
- Advise about pharmacological treatments for nicotine dependence
- Assess occupation e.g. dusty conditions
- Schedule follow up visit

D – Develop self-management plan

- Assist in the development of a self-management plan
- Check for psychosocial problems and suggest supportive strategies, such as The Australian Lung Foundation's LungNet National Support Network - 1800 654 301
- Refer for pulmonary rehabilitation
- Refer to respiratory physician to:
 - Clarify diagnosis
 - Consider other therapies
 - Consider long-term home oxygen
 - Facilitate pulmonary rehabilitation
- Refer to hospital if:
 - Inadequate response to ambulatory management
 - Inability to walk between rooms when previously mobile
 - Inability to eat or sleep because of dyspnoea
 - Altered mental status suggestive of hypercapnia
 - Worsening hypoxaemia or cor pulmonale
 - Newly occurring arrhythmia
 - Cannot manage at home
 - High risk comorbidity condition

X – Manage eXacerbations

- Ensure understanding of exacerbations and importance of early action and treatment at home if possible
- Consider need for controlled oxygen
- Inhaled bronchodilators, oral glucocorticoids and antibiotics are effective
- Review regularly

