Chronic obstructive pulmonary disease in South Africa: Under-recognised and undertreated

Chronic obstructive pulmonary disease (COPD) is a common, preventable but incurable condition currently ranked third in global mortality estimates.[1] Worldwide, 65 million people are estimated to have moderate to severe COPD, and the disease accounts for 3 million deaths annually, of which 90% are said to occur in low- and middle-income countries. Yet, despite these staggering numbers, COPD remains both under-recognised and undertreated in most populations, also in South Africa (SA).[2] There are many reasons for this, not least of which is the attitude of clinicians, which can often be fatalistic with regard to COPD. This edition of CME highlights key aspects of the diagnosis[3] and treatment – pharmacological[4] and non-pharmacological[5] – and new developments in the management of severe disease.[6] Furthermore, we have included articles focusing on non-smoking-related COPD[7] and tips for good spirometry.[8]

COPD is often a challenging disease for the patient and the doctor. Even the name causes much head-scratching for many sufferers. 'Asthma I know', and 'emphysema I have heard of', but COPD – a complex syndrome extending from chronic bronchitis to emphysema – is not well understood or easily explained. This is in part a problematic historical nomenclature issue, but as knowledge grows, there are increasing attempts to split COPD into more clinically relevant phenotypes. It is hoped that this will allow for a clearer understanding and better treatment choices.

Tobacco smoking is still the predominant cause of COPD worldwide, but there is a growing understanding of the importance of non-tobacco causes. SA is unique in many ways, having significant contributions from tuberculosis, HIV and biomass as well as mining exposure, creating 'colliding epidemics', with resultant chronic lung disease.[9] Unfortunately, very little is known about the natural history or the response to therapy of these non-smoking forms of COPD, which are currently receiving due attention. For smoking-related COPD, it is critical that smokers cease smoking; the South African Clinical Practice Guideline is available to assist clinicians in helping their patients quit.[10]

So why bother making a diagnosis of COPD and distinguishing it from asthma? This is a critical question, especially in resource-limited settings with limited access to spirometry and few treatment options. The first good reason we would propose is 'managing expectations' for both the physician and patient. Many patients are resigned to their chronic symptoms; however, if truly asthmatic, neither party should accept this lightly. In most asthma patients complete control of symptoms is possible with good therapy.[11] In COPD, by contrast, complete symptom resolution is not necessarily realistic. However, with the arrival of new long-acting muscarinic antagonists and ultra-long-acting β_2-agonists, improvement in symptom control may be dramatic. Secondly, the long-term prognosis is significantly worse in COPD compared with asthma and patients need to be appropriately counselled regarding their expected disease progression. The final reason is the choice of drugs to manage the disease. Inhaled corticosteroids are undoubtedly the mainstay of asthma therapy[12] compared with COPD, where bronchodilators are the anchor and inhaled corticosteroids are reserved for a select group.[2]

Hope is not lost with COPD. Despite it being incurable, with irreversible lung function impairment, much can still be done. Early detection and smoking cessation will slow the disease progression. Appropriate and adequate therapy to improve symptoms and prevent the ominous progression of acute exacerbations, in addition to vaccination, pulmonary rehabilitation and good nutrition, will ensure that COPD patients continue to live active lives. Novel therapies are being developed and evaluated in SA, which could potentially improve symptoms of patients with the most severe disease. Consider the diagnosis early, confirm it with spirometry and treat the patient with renewed enthusiasm!

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