



Home Study Activity With Podcasts

Clinical Decision Points:
Profiles in Patient Care for Nurse Practitioners and Physician Assistants
Based on a Series of National CME/CE Symposia

Q&A: COPD/Asthma

What Your Colleagues Around the Country Want to Know...

Q: How has inhaler technique changed with the advent of newer delivery systems that do not contain chlorofluorocarbons (CFCs) as a propellant?

A: Studies completed with the new metered-dose inhalers (MDIs) that contain hydrofluoroalkane (HFA) were done using a technique without a spacer, so it appears that patients can achieve adequate inhalations using HFA MDIs without a spacer. Whether to use or not to use spacers has always been an interesting issue. Spacers can be helpful for children, the elderly, or patients who have coordination problems. While many clinicians, including respiratory therapists, feel the closed-mouth technique is best for using the newer HFA MDIs, others prefer the open-mouth technique. Often patients pay less attention to what they are doing when they use the open-mouth technique.

The main point is that clinicians need to ask patients to bring MDIs to every visit and have someone watch as they demonstrate their technique.

Q: What is the appropriate interval following bronchodilation to repeat the spirometry measurement?

A: After having the patient take 1 inhalation of the bronchodilator, it is important to wait 30 seconds before the second inhalation. After the second inhalation, it is important to wait a minimum of 5 minutes before repeating the spirometry measurement. While the bronchodilator works for up to 2 hours, it is important to repeat the measurement no more than 20 minutes after the second inhalation.



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Q: How essential is it to perform spirometry in patients with suspected or confirmed chronic obstructive pulmonary disease (COPD)?

A: Spirometry is essential for diagnosing COPD and assessing disease progression. It is important to note that results of spirometry change the diagnosis in up to 20% of patients that are initially “thought” to have COPD. Thus, spirometry is critical to achieving a definite diagnosis of COPD. Spirometry also is useful for monitoring disease progression. Pharmacotherapy recommended in the Global Initiative for Chronic Obstructive Lung Disease guidelines was developed based on level of disease severity, which is defined in terms of spirometric measures.

Q: If a patient claims to have been diagnosed with COPD, but has never had spirometry performed, should the patient discontinue medications prior to being tested?

A: The answer depends on the patient’s disease severity. Many clinicians do have COPD patients temporarily stop their medications in order to obtain spirometric measures. The general approach is to ask the patient to refrain from taking bronchodilator medications the night before and the morning of the spirometry measurement and to perform the test midmorning. Early morning spirometry is discouraged because that is when pulmonary function is at the lowest.

Q: Will an oxygen (O₂) saturation measurement provide objective information about a patient’s breathing status and help guide management of treatment?

A: Yes. When the O₂ saturation level is normal, the clinician can be confident there is no need for emergency intervention. In that way, it helps to triage patients on the basis of severity. Generally, when saturation is approximately 90% or 92%, the clinician should be concerned and should move to the next step, which would be to obtain a blood gas. It may also be important to know whether or not the patient desaturates with exercise. If this happens, obtaining a blood gas would be prudent.



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Q: What is the appropriate schedule for initiating and tapering therapy with oral prednisone?

A: Oral corticosteroids are reserved for exacerbations in treatment of COPD. The only other role for this class of medications is perhaps in managing very severe end-stage disease. A reasonable oral corticosteroid regimen for a COPD exacerbation would be to start at a 10-mg or 20-mg dose daily for 7 to 10 days. When using this regimen, there is no need to taper off unless the patient is very frail.

Q: Are there key clinical pearls to help guide diagnosis and treatment of COPD?

A: COPD is a common respiratory disorder with increased mortality, especially in women—be aware of gender bias and the tendency to ignore the possibility of COPD in women. Patients with COPD may gradually adapt to lung changes and not recognize their symptoms. COPD and asthma can be difficult to differentiate, but the key is spirometry.