CHRONIC LUNG DISEASE

A/Prof Goh Lee Gan

SFP2013; 39(2): 4

The theme of this Family Practice Skills Course is Chronic Lung Disease and the spotlight is on Chronic Obstructive Pulmonary Disease (COPD). This condition is the 6th chronic disease identified in its 10 chronic conditions in the Ministry of Health's Chronic Disease Management Programme (CDMP).

A few more numbers to add to COPD. MOH has identified COPD as one of the 5 disease conditions amenable to intervention via an integrated care pathway (ICP). COPD was the 7th principal cause of death in Singapore with about 440 deaths. COPD was also the 7th most common condition for hospitalisation with more than 10,000 admissions in 2010.

The first unit in this Family Practice Skills Course dealt with the epidemiology of COPD. The key point to note is that it is under-recognised and under-diagnosed. COPD is more likely to be reported as contributory rather than the underlying cause of death or morbidity. In elderly patients, most cases of COPD are undiagnosed, because they are attributed to old age or labelled as asthma. A past history of asthma is often elicited in patients with COPD, and is a recognised risk factor for COPD, but COPD and asthma as distinct co-existing diseases are seldom clinically recognised as such. In developing countries, past tuberculosis is also common, and recent studies support its role as a risk factor for COPD.

In Unit 2, the guidelines for COPD and non-pharmacological interventions are discussed. Evidence on the natural history of COPD demonstrates that early institution of long acting bronchodilator therapy slows the rate of lung function decline and reduces frequency of exacerbations that can lead to further functional decline. The goals of therapy are symptom control, reduce exacerbations, and maintain quality of life. Smoking cessation is worthwhile at any stage of the disease.

In Unit 3, we note that the 2011 revision of the GOLD global strategy on COPD is a major paradigm shift in diagnosis and management of the disease. Detailed assessment of current symptom control and future risk of exacerbation allows categorisation of the patient into one of 4 categories, each with pharmacological interventions linked to each of these categories.

Units 4 deals with the overlap "syndrome" of asthma & COPD, with a new label of Asthma-COPD Overlap "Syndrome" (ACOS). The key take home message is such patients have high disease burden compared to the asthma alone or COPD alone patient. They are also at increased risks of frequent exacerbations and therefore their treatment should be optimised before hospital discharge. Also rehabilitation immediately after an exacerbation has been shown to be safe and effective to prevent further exacerbations requiring hospitalisation.

Unit 5 focuses on pulmonary rehabilitation (PR). This has emerged as a standard of care for patients with COPD. PR identifies and treats the systemic effects of the disease and the positive outcomes are achieved without demonstrable improvements in lung function. It is multidisciplinary, patient centred and provides a comprehensive assessment upon which the three components of exercise training, self-management education, and psychosocial/behavioural intervention are conducted over a period lasting 6 to 12 weeks.

Unit 6 focuses on a team based approach to managing chronic lung disease that is being implemented by JurongHealth as its first Integrated Care Pathway (ICP) model of care. In the COPD ICP Team approach, the execution of care is based on 5 interdependent tenets: (1) Every patient has a primary care physician; (2) Every patient's care should be delivered as a set, rather than individual components; (3) Every patient has a single health record; (4) Every care process must represent value to the patient; (5) Every patient must be helped to navigate care, and supported to remain in care. Of note is the care is supported by care managers, communication links for tracking response to therapy, IT support, and equipment support.

The PRISM column in this issue has a paper on managing a 14-year-old female teenager presenting with a sexually transmitted infection. It is a good case to learn vicariously what should be done. In Singapore, sex with a minor is considered a seizable offence. The law dictates that anyone aware of such an offence being committed has a duty to inform the authorities. Doctors often come across this type of sticky situation and are sometimes unsure of what to do next. The paper deals with the ethical and legal considerations when faced with such a situation. A necessary read for all practitioners.

GOH LEE GAN, Professorial Fellow,
Division of Family Medicine, University Medicine Cluster,
National University Health System; Director of Academic Development,
Institute of Family Medicine, College of Family Physicians Singapore