Study of Chronic Obstructive Pulmonary Disease Patients in Suez Chest Hospital

Thesis submitted for partial fulfillment of the Master degree in Chest diseases

By Moustafa Salah Mohammed M. B., B.Ch, Ain shams University

Under the supervision of

Prof. Yasser Moustafa Mohammed

Professor of Chest diseases,
Faculty of Medicine,
Ain Shams University

Prof. Gehan Mohammed El Assal

Professor of Chest diseases,
Faculty of Medicine,
Ain Shams University

Faculty of Medicine Ain Shams University 2015



الأية 32 سورة البعرة

<u>Acknowledgement</u>

Thanks to Allah as we owe him for his great care, support and guidance in every step in our life.

My deepest appreciation and honest feelings are to be expressed towards *prof. Yasser Moustafa Mohammed* Professor of chest diseases, Faculty of Medicine, Ain Shams University, for his unlimited help, continuous encouragement and kind supervision. longanimity

I wish to express my sincere feelings of gratitude to *prof. Gehan Mohammed El Assal*, Professor of chest diseases, Faculty of Medicine, Ain Shams University, for her valuable scientific guidance, support, supervision, patience, and unlimited help.

Also deepest thanks and profound gratitude to *prof. Mohammed Farrag* For his great support and help for achieving this work.

Thanks to my family for their continuous encouragement during the course of this study

List of Contents

	Page
i- Acknowledgement	I
ii- List of contents	II
iii- List of Abbreviations	IV
iv- List of Tables	VII
v- List of Figures	IX
Introduction	1
Aim of the work	3
Review of literature	4
Definition	4
Burden of COPD	6
Smoking prevalence in Egypt	14
Risk factors	16
Pathogenesis	27
Pathology	32
Pathophysiology	37
Clinical feature of COPD	41
History	41
Examination	44
Investigations	46
Spirometric classification of COPD	48
Combined COPD Assessment	62
Management of COPD	64
Patients & Methods	93

Results	110
Discussion	133
Summary	149
Recommendations	153
References	155
Appendix	189
Arabic summary	

List of abbreviations

AAD: Alpha 1 Antitrypsin Deficiency.

ATS: American Thoracic Society.

BMI: Body mass index.

BODE: B (body mass index), O (airflow obstruction), D (dyspnea) and

E (Exercise capacity).

BLT: bilateral lung transplants.

BOLD: The Burden of Obstructive Lung Disease.

BRFSS: Behavioral Risk Factor Surveillance Survey.

CAT: COPD Assessment Test.

Cm: centimeter.

CD4: cluster of differentiation 4 CD8: cluster of differentiation 8

CHRNA3/5: alpha-Nicotinic acetylcholine receptor.

CMV: Cytomegalovirus

COPD: Chronic obstructive pulmonary disease.

CT: Computed tomography.

CXR: Chest x ray.

DALYs: Disability Adjusted Life Years.

D_LCO: Diffusing capacity of carbon monoxide.

DM: Diabetes Mellitus.

€: Euro.

ECOPD: Exacerbation of Chronic obstructive pulmonary disease.

ERS: The European Respiratory Society.

ETS: Environmental Tobacco Smoke.

ESCT: Egyptian Society of Chest Diseases and Tuberculosis.

FAM13A: Family with sequence similarity 13, member A1.

FDG PET-CT: Fluorodeoxyglucose positron emission tomography-computed Tomography.

FEF: Forced Expiratory Flow.

FEV1: Forced expiratory volume in first second.

FEV₁/FVC: Forced expiratory volume in first second/ forced vital capacity.

FVC: Forced vital capacity.

GOLD: Global Initiative for Chronic Obstructive Lung Disease.

GP: general practitioner.

GWAS: Genome-wide association studies.

HHIP: Hedgehog-interacting protein.

HRQOL: Health related quality of life.

Hrs. Hours.

HS: Highly Significant. ICU: Intensive care unit

IL-1B: Interleukin-1B

IL-8: Interleukin8.

IL-6: Interleukin6.

IM: Intramuscular.

IV: Intravenous.

KCO: The transfer coefficient of carbon monoxide.

Kg/m²: kilogram/meter square.

Kpa: kilopascal.

LE: Egyptian pound.

LLN: Lower Limit of Normal.

LTB4: leukotriene B4.

LVRS: Lung Volume Reduction Surgery.

Min: Minute.

Mm: Millimeter.

MMP: Matrix metalloproteinase

Ml: Milliliter.

MMRC: Modified medical research council. NETT: National Emphysema Therapy Trial.

NHLBI: National Heart, Lung, and Blood Institute.

NHIS: National Health Interview Survey.

NICE: National Institute for Health and Clinical Excellence.

NIV: Noninvasive ventilation.

NS: Non-Significant

No.: Number.

PaCO2: Arterial partial pressure of CO2.

PaO2: Arterial partial pressure of oxygen.

Pemax: Maximum expiratory pressure.

PH: power of Hydrogen

PHT: Pulmonary Hypertension.

Pimax: Maximum inspiratory pressure

PLATINO: Latin American Project for the Investigation of

Obstructive Lung Disease Team(Proyecto Latinoamericano de

Investigacio n Obstruccio n Pulmonar)

PR: pulmonary Rehabilitation.

PROs: Patient Reported Outcomes.

QCT: Quantitative Computed Tomography

SABAs: Short-Acting Bronchodilators

SaO₂: Oxygen Saturation.

SD: Standard Deviation.

SLT: Single Lung Transplants.

SPSS: Statistical Program for Social Science.

SR: Sustained Release.

TC1: tissue culture number one

TGF- β : Transforming Growth Factor- Beta.

TIMPs: Tissue Inhibitor of Metalloproteinases

TNF: Tumor Necrosis Factor alpha.

TORCH: Toward a Revolution in COPD Health

\$:Dollar

UK: United Kingdom.

μg: Microgram. US: United States.

V_A/Q: Ventilation/Perfusion ratio mmHg millimeter mercury.

VO2 max: maximum Volume of Oxygen

WHO: World Health Organization.

YLD: Years of Living with Disability.

List of tables

Table	Title	Page
I	Canadian Thoracic Society COPD Classification by symptoms/disability.	49
II	Egyptian guideline for management of COPD.	50
III	Global initiative for Obstructive Lung Disease, 2014 classification.	51
IV	Strategies to Help the Patient willing to quit.	67
V	Benefits of Pulmonary Rehabilitation in COPD.	70
VI	Pharmacologic Management of COPD.	75-76
1	Distribution of COPD patients as regards the service provided.	111
2	Comparison between the studied groups as regards general data.	112-113
3	Distribution of COPD patients as regards number of trials to quit smoking.	116
4	Distribution of COPD patients as regards symptoms.	117
5	Distribution of COPD patients as regards number of mild to moderate and severe exacerbations in the last year.	118
6	Distribution of COPD patients as regards number of previous hospitalization in the last 3 years due to chest diseases.	120
7	Distribution of COPD patients as regards follow up doctor.	121
8	Distribution of COPD patients as regards body mass index.	121

9	Distribution of COPD patients as regard	122
	BODE index.	122
10	Available doctor prescription pattern of antibiotics among 200 COPD patients.	123
11	Systemic drugs used by COPD patients.	124
12	Distribution of other drugs used by COPD patients.	124
13	Inhalers used by COPD patients.	125
14	Drugs used in nebulizer used by COPD patients.	126
15	Comparison between the studied groups as regards prefer of inhalation therapy.	126
16	Distribution of COPD patients according to Patient Education & Rehabilitation	127
17	Distribution of COPD patients as regards family history of chest disease.	127
18	Distribution of the most common comorbidities associated with COPD patients	128
19	Distribution of the most common complications associated with COPD patients.	129
20	Classification of COPD patients as regards the disease severity based on Global Initiative for Obstructive Lung Disease, 2013.	130
21	Association Between Symptoms, Spirometric Classification, and Future Risk of Exacerbations.	131
22	Correlation between FEV1%, FVC%, FEV1/FVC% and FEF % after versus different variables among the studied group.	132

List of Figures

Figure	Title	Page
I	Pathogenesis of COPD.	31
II	Pathological Changes of the Central Airways in COPD.	33
III	Pathological Changes of the Peripheral Airways in COPD.	33
IV	Relationship Between Health-related Quality of Life, Post-bronchodilator FEV1 and GOLD Spirometric Classification.	60
V	Association between Symptoms, Spirometric Classification, and Future Risk of Exacerbations	62
VI	Fletcher's graph.	68
VII	schiller spirovit sp-1spirometer	94
1	Distribution of COPD patients as regards family size.	113
2	Distribution of COPD patients as regards education level.	114
3	Distribution of COPD patient as regards employment	114
4	Distribution of COPD patients as regards smoking status and type of smoking.	115
5	Distribution of COPD patients as regards number of trials to quit smoking.	116
6	Distribution of COPD patients as regards grade of dyspnea.	117
7	The percentage of COPD patients who had non severe exacerbations according to the number of attacks.	119

8	The percentage of COPD patients who had severe exacerbations according to the number of attacks.	119
9	Distribution of COPD patient as regard number of previous hospitalization in the last 3 years due to chest diseases.	120
10	Distribution of COPD patient as regards BODE index.	122
11	Distribution of COPD patient as regards antibiotics selection.	123
12	Distribution of COPD patient as regards Inhalers.	125
13	Distribution of COPD patient as regards the most common comorbidities.	128
14	Distribution of COPD patient as regards Complications.	129
15	Distribution of COPD patients as regards the disease severity according to Global Initiative for Obstructive Lung Disease, 2013.	130
16	Association Between Symptoms, Spirometric Classification, and Future Risk of Exacerbations	131
17	Relation between FEV1 % of predicted in COPD patients and packets/yr	132

Introduction

Chronic Obstructive Pulmonary Disease (COPD) is a common preventable and treatable disease is characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients (*GOLD*, *2015*).

COPD has been a major public health problem during the 20th century, and will remain a challenge for the foreseeable future. Worldwide, COPD is in the spotlight, because its high prevalence, morbidity, and mortality create formidable challenges for healthcare systems (*Joan et al.*, 2011).

Cigarette smoking is the major risk factor for COPD passive smoking, indoor air pollution, occupational dust exposure and genetic factors are recognized as potential factors contributing to the development of COPD (*Viegi et al.*, 2007).

COPD is frequently associated with other diseases. There is consistent evidence that these comorbidities have a

Introduction

greater negative impact in COPD patients in terms of quality of life, exacerbation and mortality. Thus, diagnosis and management of comorbidities is an important challenge for the COPD patient (*A Cavaille*'s *et al.*, *2013*).

COPD affects about 10% of the general population, but its prevalence among heavy smokers can reach 50% (Cosio et al., 2009).

According to the World Health Organization (WHO), COPD will become the third commonest cause of mortality, and the seventh commonest cause of disability adjusted life years worldwide by 2030 (*Sara Maio et al.*, 2012).

The epidemiology, demographic, clinical characteristic of the patients and prescription pattern vary significantly between studied Egyptian COPD patients and other studied in different countries; which highlight individuality of each country and necessity of national data on our health problems (*Elsayed*, 2007).

Prevalence, morbidity and mortality in Egypt are still lacking and have to be estimated; however COPD is arising significant health problem in Egypt (*Egyptian Society of Chest Diseases and Tuberculosis*, 2003).

Review of Literature

Aim of the work

The aim of this work is to study two hundred COPD patients in Suez Chest Hospital divided equally to one hundred patients attending outpatients clinic and one hundred patients admitted to the hospital during period from January 2013 to June 2014 as regard: demographic characteristic of the patients, clinical characteristic of the patients and available prescription pattern.