COPD, COLD, CAO, Etc.

Anachronistic Acronyms

Chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), chronic airway obstruction (CAO), chronic non-specific lung disease (CNSLD), and other similar terms have been used for many years by physicians to describe a group of chronic pulmonary disorders associated with obstruction of airflow. At a time when differentiation between the disorders comprising this complex of symptoms was difficult and when our understanding of the natural history of the disorders was minimal, this vague terminology may have served a useful purpose in daily clinical practice. The continued use of the term, "COPD," is, in the light of present-day knowledge, misleading and hides important information. This term gives the physician the impression that an accurate diagnosis has been made, even if this is not so. The term may connote to the patient that he or she suffers from a progressively incurable disease, which also may be erroneous. The term, "COPD," fails to take into account the difference in etiology, pathologic abnormalities, and natural history of the patient's disease.

In 1978, we now can distinguish with a reasonable degree of accuracy between the disorders comprising COPD, even though many patients have several of these entities coexisting. Also, we now have a better understanding of the course of these diseases. Chronic bronchitis, when defined in terms of hypersecretion of mucus and when not accompanied by emphysema, is a benign disease; it does not necessarily lead to progressive obstruction of the airflow. Emphysema, on the other hand, is a progressive disease. Bronchiectasis, which at times is "lumped" under the heading of COPD, may not be a progressive problem, although there is minimal long-term follow-up data available on medically treated patients in the antibiotic era. Asthma also has been "lumped" under the heading of COPD, and this certainly is a different disorder from chronic bronchitis and emphysema, although long-term follow-up studies on large groups of asthmatic subjects have not been reported. Even cystic fibrosis is often put into the category of COPD.

The terms, COPD, COLD, etc, are used by chest physicians primarily to describe patients who have chronic bronchitis (as defined clinically) combined with emphysema, since the two often coexist. We have also noted that a degree of bronchospasm comparable to that seen in some patients with allergic asthma also frequently accompanies bronchitis and emphysema (unpublished data). If the use of the term, COPD, could be confined to the diagnosis of disease due to a mixture of chronic bronchitis and emphysema, it might be a reasonable term; however, physicians less sophisticated in thoracic medicine at times use COPD for any pulmonary disorder which is chronic and in which obstruction of airflow is present.

A possible alternative to the use of the term, COPD, is a modification of the New York Heart Association's method of diagnosing cardiac disease. This could include the diagnosis as made by clinical information, as well as the etiologic, anatomic, and physiologic diagnosis, followed by the extent of functional disability. Thus, a hypoxic patient with advanced chronic bronchitis, emphysema, and bronchospasm would be diagnosed as follows:

Clinical: Chronic bronchitis and emphysema;
Etiologic: Cigarette smoking and alpha-antitrypsin deficiency;
Anatomic: Hyperplasia of mucous glands and emphysema;
Physiologic: Severe obstruction of airflow that is partially reversed by inhalation of a bronchodilator drug, and severe hypoxemia corrected by therapy with supplemental oxygen;
Functional Class: 3 (comfortable at rest, with symptoms occurring with mild exertion).

Although this scheme is more cumbersome to use than the term, COPD, it has the advantage of accurately describing the patient's disease and what can be done to help that individual. Committees
involved in standardizing the nomenclature of thoracic medicine (pulmonology?) may wish to give this scheme consideration.

In conclusion, nonspecific terms used in the diagnosis of chronic bronchitis, emphysema, and other disorders resulting in a decrease in the rate of expiratory airflow from the lungs are not adequate and should be dropped. Specific diagnoses can and should be made, so that both physician and patient have an understanding of that patient's disease, an understanding as comprehensive as can be provided by current scientific knowledge.

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References

1 Pulmonary terms and symbols: A report of the ACCP-ATS Joint Committee on Pulmonary Nomenclature. Chest 67: 583-593, 1975

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