that. This, however, is a small group of patients. More common are patients who present with cough and wheezing and are considered to have atypical asthma. It is possible by analysis of these patients with esophageal pH monitoring to show that in some the symptoms are precipitated and caused by episodes of gastroesophageal reflux. This does not necessarily mean that gross aspiration is taking place, as both microaspiration and reflux acidification of the esophagus can cause reflex bronchoconstriction and asthmatic symptoms. Correction of the reflux in these patients can eliminate their pulmonary symptoms. Pulmonologists should be alert that when patients present in an atypical fashion, at atypical ages, or when symptoms are related to factors that exacerbate reflux, then that diagnosis should be considered and investigated.

In 1989, the Fifth Conference of The International Society for Diseases of the Esophagus will take place in Chicago under the sponsorship of The American College of Chest Physicians. We hope that the members of the ACCP and readers of this journal will see this as an opportunity to clarify the interrelationships between the three chest organs for the mutual benefit of physicians and patients.

Alex G. Little, M.D., F.C.C.P.
Chicago

REFERENCES


COPD, We Hardly Knew Ya!

From the time of its appearance as an attempt to unify British and American terminology, the term chronic obstructive pulmonary disease (COPD) was not a particularly favored term until it crept into medical texts in the late 1960s. The original intent of the term and the patient group to which it was intended was noted in 1979, but alas, the horse was out of

the barn. The American love of jingoistic simplification would not be denied and the literature became crowded with articles titled with the convenient lumping together of emphysema, chronic bronchitis, and asthma. Not everyone was happy with the term. After all, is a low FEV₁ secondary to loss of lung recoil really an obstructive disease? Well, how about chronic airflow limitation (CAL)? (Here we go again!) It now seems that asthma is out and peripheral airways obstruction is in.

I have objected to the term in teaching students, patients, and colleagues for many years. My objections are these:

1. Most of my patients are referred by other physicians and have already been tagged as having COPD when they arrive in my office. Typically, a well-meaning radiologist has seen hyperinflation on a chest film and said, "This patient has COPD." To the majority of practicing primary care physicians, this means only one thing—emphysema. Most of these patients have never had pulmonary function tests when I first see them, and their subsequent diagnoses range from bronchiectasis to normal lungs! If I then return the patient to the referring physician signed out as COPD, the understanding and treatment of this patient's disease process has not been well-served. If, on the other hand, a careful investigation leads me to the conclusion that within the limits of the technology available to me the patient has pulmonary emphysema, then I can outline a good home care program and draw a distinction between the patient's likely subsequent course and that of the chronic bronchitis patient. Isn't this better?

2. For years, I have watched semi-bored medical students trudge to the bedside, perform a cursory history and physical on a dyspneic smoker with hyperinflated lungs and proceed to dictate their findings ending with the obligatory "impression: COPD." In mock rage, I usually tell them my precocious 12-year-old daughter could do that and be no less intellectually sloppy. I would submit that if the above is good medicine, we don't need pulmonary function laboratories. I do expect my students to stick their necks out, document a calculated estimate of the likely pathophysiology, and await the pulmonary function test results.

3. The lay and medical media and various patient education groups all publish informational material ("COPD and You") in the hopes of enhancing patient comprehension of their disease. I recall the anguished patient who rushed into my office exclaiming, "I thought you said I had chronic bronchitis!" "Yes, I believe that's correct." "Well,
the therapist at my breather club says I have COPD and my pharmacist-neighbor says that is emphysema." Well, you get the picture and, frankly, I have not been impressed that this campaign against the term COPD by myself and a small cadre of like-minded zealots has gotten anywhere nor made many friends. An amused colleague back East calls it the "classification of poor doctors!"

Now comes the dawning of the age of DRGs, PROs, and HCFA. And what do you know? They don’t like COPD! They have found that this diagnosis is No 5 on the all-time list of top ten diagnoses, garners 2 percent of the total Part A budget (a big number, folks), and is the most misclassified or misdiagnosed of all DRGs. I suppose this was predictable, given the lack of scientific consensus as to what the term means.\(^2\)\(^4\) The Inspector General’s Office (IGO) recently conducted an investigation of the charts of 272 patients discharged with this diagnosis in the Midwest; 65 percent were erroneously classified and, according to the IGO, in every case this "error" was in favor of the hospital toward a heavier DRG weight. They suspect fraud—I smell ignorance. Were any pulmonologists involved in their investigation? No. Are most physicians aware that COPD carries a heavier weight than, say, pneumonia or acute bronchitis? I don’t think so. Where is the gain for a physician to "game" the system in this manner?

The IGO suggested that many of us work for the hospital and have a vested interest. I’ll wager that less than 5 percent of these 272 patients were admitted by hospital-based pulmonologists.

I’ve always wanted COPD to exit quietly, but this isn’t what I had in mind. It would be a terrible irony if a spirited scientific debate were quashed by bureaucrats playing statistical games. I assume we never would have heard from them if the "misdiagnosis" favored a lower weight DRG! Now is the time to say we need more data and you can send that research grant check in care of the undersigned, but realistically, this issue can only be resolved by a thoughtful reassessment of approach to this diagnosis in our medical schools and pulmonary divisions.

\textit{Louis W. Burgher, M.D., F.C.C.P.}

\textit{Omaha}

Pulmonary Medicine Service, Bishop Clarkson Memorial Hospital. \textit{Reprint requests: Dr. Burgher, Pulmonary Medicine, Clarkson Hospital, PO Box 3328, Omaha 68103-0328}

\textbf{REFERENCES}

4. Renzetti AD. The natural history of COPD. Pulmonary Perspectives 1986; 3:6-8