Česká data
o výskytu fenotypů CHOPN

Vladimír Koblížek

Plicní klinika FN a LF UK Hradec Králové

Which SCIDs Require Preregistration?

These SCIDs require preregistration:

- The "A to ZZ" of COPD: A Pragmatic Approach to Management of COPD Geneotypes, Phenotypes, and Comorbidities
- Acute Exacerbation of COPD: Practical Strategies to Improve Outcomes and Reduce Readmission Rates
- Chronic Thromboembolic Pulmonary Hypertension: Background, Evolution, and Management
- Counseling on Tobacco Cessation *(Tuesday session only)*
- Hot! Hot! Hot! Drug-Related Hyperthermia in the ICU *(Tuesday session only)*
- Idiopathic Pulmonary Fibrosis Update
- What's New in Pulmonary Arterial Hypertension?

Rozdělení nemocných do „skupin“ – budoucnost cílené léčby ??

Thorax. 2013 Sep 12. doi: 10.1136/thoraxjnl-2013-203897. [Epub ahead of print]

Design of the Subpopulations and Intermediate Outcomes in COPD Study (SPIROMICS).

Couper D, Lavange LM, Han M, Barr RG, Bleecker E, Hoffman EA, Kanner R, Kleerup E, Martinez FJ, Woodruff PG, Rennard S; for the SPIROMICS Research Group.

Collaborators (24)

Department of Biostatistics, University of North Carolina at Chapel Hill, , Chapel Hill, North Carolina, USA.

Abstract

Subpopulations and Intermediate Outcomes in COPD Study (SPIROMICS) is a multicentre observational study of chronic obstructive pulmonary disease (COPD) designed to guide future development of therapies for COPD by providing robust criteria for subclassifying COPD participants into groups most likely to benefit from a given therapy during a clinical trial, and identifying biomarkers/phenotypes that can be used as intermediate outcomes to reliably predict clinical benefit during therapeutic trials. The goal is to enrol 3200 participants in four strata. Participants undergo a baseline visit and three annual follow-up examinations, with quarterly telephone calls. Adjudication of exacerbations and mortality will be undertake

KEYWORDS: COPD Exacerbations, COPD epidemiology, Emphysema, Imaging/CT MRI etc

Postupně se dělení nemocných do „skupin“ ujímá

ve velkých klinických studiích - příklad non-AE

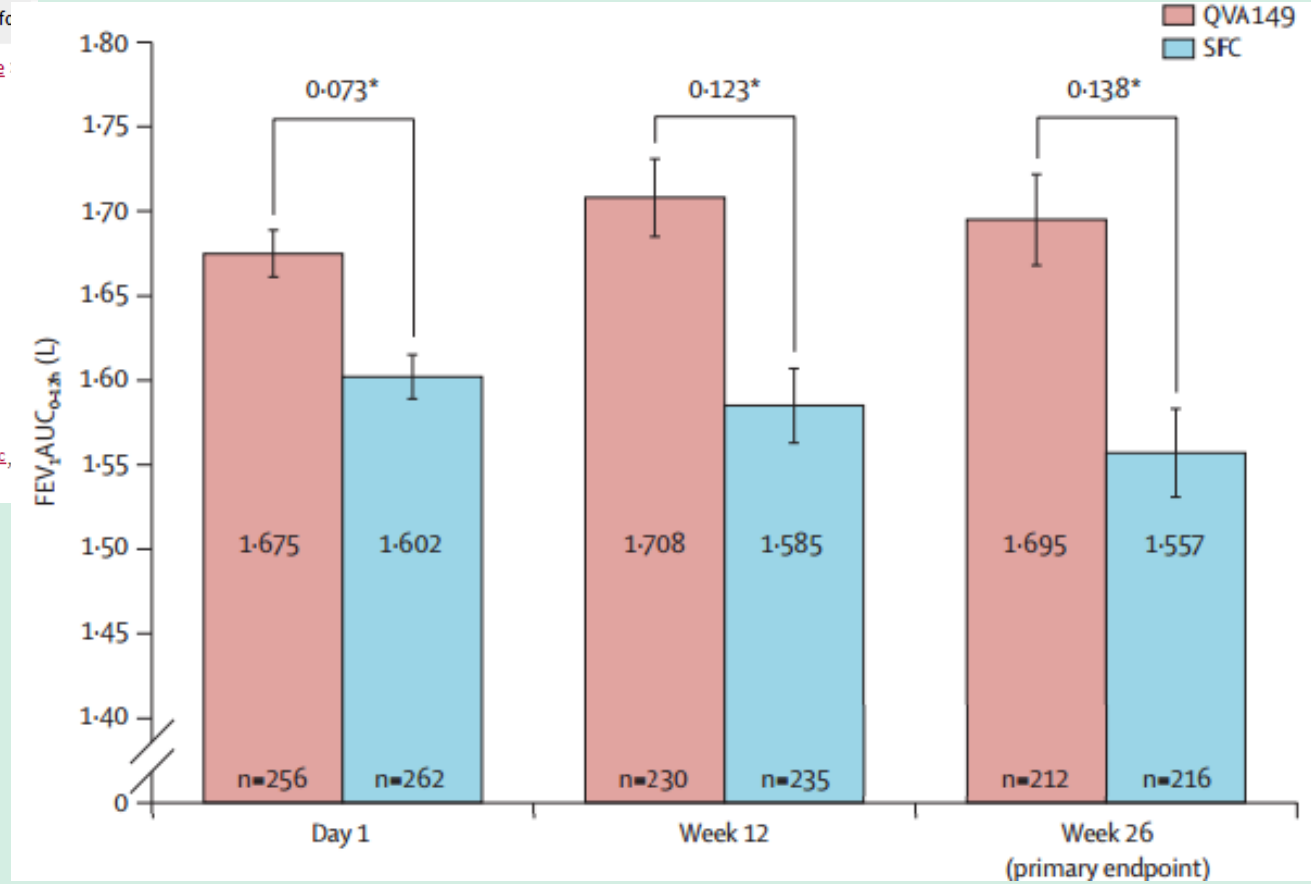
THE LANCET Respiratory Medicine

The Lancet Respiratory Medicine, Volume 1, Issue 1, Pages 51 - 60, March 2013
doi:10.1016/S2213-2600(12)70052-8 Cite or Link Using DOI
This article can be found in the following collections: Cardiology & Vascular Medicine; Respiratory Medicine (COPD)
Published Online: 06 December 2012

< Previous Article | Next Article

Efficacy and safety of once-daily QVA149 compared with twice-daily salmeterol—fluticasone in patients with chronic obstructive pulmonary disease (ILLUMINATE): a randomised, double-blind, parallel group study

Prof Claus F Vogelmeier MD [a], Prof Eric D Bateman MD [b], John Pallante BS [c], Vijay KT Alagappan MD [c], Peter D'Andrea MD [c], Hungta Chen PhD [c], Donald Banerji MD [c]



Příklad atopické skupiny CHOPN

Respiratory Research

BioMed Central
The Open Access Publisher

Atopy is a risk factor for respiratory symptoms in COPD patients: results from the EUROSCOP study

Respiratory Research 2013, **14**:10 doi:10.1186/1465-9921-14-10

Fatemeh Fattahi (f.fattahi@umcg.nl)
Nick H ten Hacken (n.h.t.ten.hacken@umcg.nl)
Claes-Göran Löfdahl (Claes-Goran.Lofdahl@med.lu.se)
Machteld N Hylkema (m.n.hylkema@umcg.nl)
Wim Timens (w.timens@umcg.nl)
Dirkje S Postma (d.s.postma@umcg.nl)
Judith M Vonk (j.m.vonk@umcg.nl)

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Abstract

Background

The pathogenesis of COPD is complex and remains poorly understood. The European Respiratory Society Study on Chronic Obstructive Pulmonary Disease (EUROSCOP) investigated long-term effects of budesonide; 18% of the COPD participants were atopic. So far effects of atopy on the long-term course of COPD have not been elucidated.

Methods

Factors related to the presence of atopy (positive phadiatop) in 1277 mild-to-moderate COPD patients participating in EUROSCOP were analysed using regression analysis. Incidence and remission of respiratory symptoms during 3-year follow-up were analysed using generalised estimating equations models, and association of atopy with lung function decline using linear mixed effects models.

Results

Independent predisposing factors associated with the presence of atopy were: male gender (OR: 2.21; 95% CI: 1.47–3.34), overweight/obese (OR: 1.41; 95% CI: 1.04–1.92) and lower age (OR: 0.98; 95% CI: 0.96–0.99). Atopy was associated with a higher prevalence of cough (OR: 1.71; 95% CI: 1.26–2.34) and phlegm (OR: 1.50; 95% CI: 1.10–2.03), but not with lung function levels or FEV_1 decline. Atopic COPD patients not treated with budesonide had an increased incidence of cough over time (OR: 1.79, 95% CI: 1.03–3.08, p = 0.038), while those treated with budesonide had increased remission of cough (OR: 1.93, 95% CI: 1.11–3.37, p = 0.02) compared to non-atopic COPD patients.

Conclusions

Atopic COPD patients are more likely male, have overweight/obesity and are younger as compared with non-atopic COPD patients. Atopy in COPD is associated with an increased incidence and prevalence of respiratory symptoms. If atopic COPD patients are treated with budesonide, they more often show remission of symptoms compared to non-atopic COPD patients who are treated with budesonide. We recommend including atopy in the diagnostic work-up and management of COPD.

AE skupina CHOPN

THE LANCET Respiratory Medicine

The Lancet Respiratory Medicine, Volume 1, Issue 3, Pages 210 - 223, May 2013 < Previous Article | Next Article >
doi:10.1016/S2213-2600(13)70040-7 Cite or Link Using DOI
This article can be found in the following collections: Cardiology & Vascular Medicine; Respiratory Medicine (COPD)
Published Online: 19 April 2013

Once-daily inhaled fluticasone furoate and vilanterol versus vilanterol only for prevention of exacerbations of COPD: two replicate double-blind, parallel-group, randomised controlled trials

Mark T Dransfield MD [a] [†], Jean Bourbeau MD [b], Prof Paul W Jones PhD [c], Nicola A Hanania MD [d], Prof Donald A Mahler MD [e], Prof Jørgen Vestbo DMSc [f] [g] [h], Andrew Wachtel MD [i], Fernando J Martinez MD [j], Frank Barnhart DVM [k], Lisa Sanford MSc [l] [‡], Sally Lettis PhD [l], Courtney Crim MD [k], Prof Peter MA Calverley DSc [m] [†]

Methods

We did two replicate double-blind parallel-group 1 year trials. Both studies began on Sept 25, 2009. Study 1 ended on Oct 31, 2011, and study 2 on Oct 17, 2011. Eligible patients were aged 40 years or older, had a history of OPD, a smoking history of 10 or more pack-years, a ratio of forced expiratory volume in 1 s (FEV_1) to forced tal capacity of 0·70 or less after bronchodilators (and an FEV_1 of 70% or less of predicted), and a documented story of one or more moderate or severe disease exacerbations in the year before screening. Patients were ndomly assigned (1:1:1:1) on the basis of the Registration and Medication Ordering System to 25 µg vilanterol one or 25 µg vilanterol combined with either 50 µg, 100 µg, or 200 µg fluticasone furoate once daily. Our rimary endpoint was the yearly rate of moderate and severe exacerbations. The trials were analysed separately nd a pooled analysis was also done. These trials are registered with ClinicalTrials.gov (NCT01009463 and CT01017952).

indings

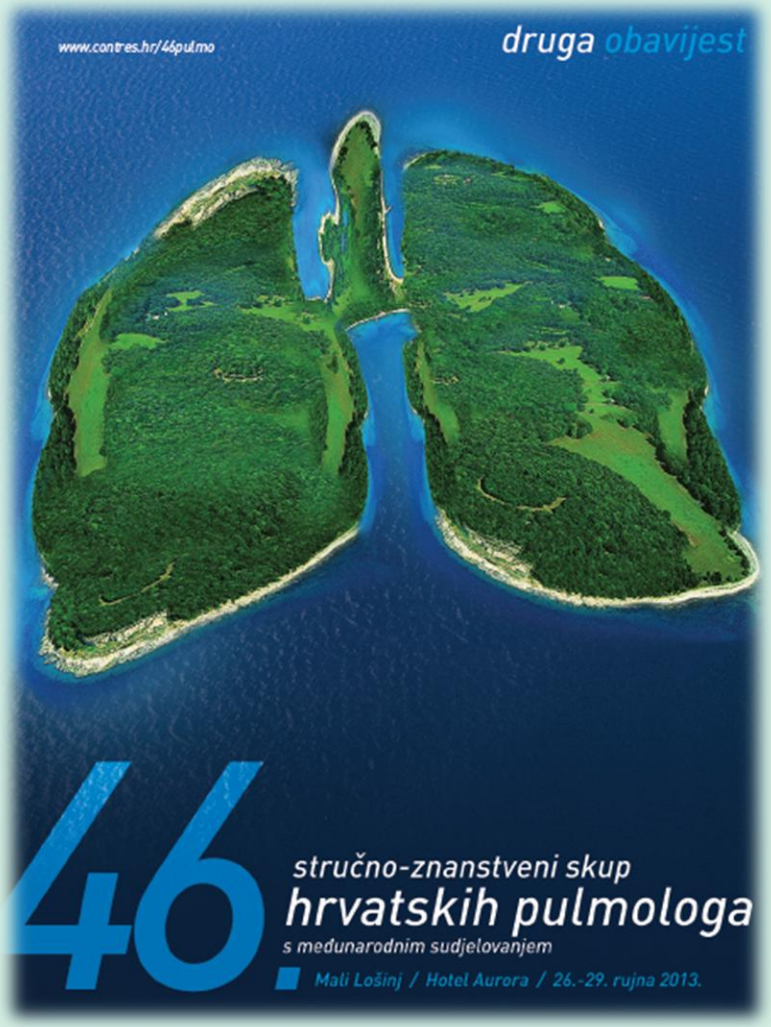
522 patients in study 1 and 1633 patients in study 2 were randomly assigned. In study 1, no significant fference in exacerbation rate was noted between the 200/25 µg fluticasone furoate/vilanterol group and the lanterol only group (mean 0·90 events *vs* 1·05 events per year; ratio 0·9 [95% CI 0·7—1·0]). Because of the atistical hierarchy used, we could not infer significance for the 50 µg and 100 µg groups. In study 2, gnificantly fewer moderate and severe exacerbations were noted in all fluticasone furoate/vilanterol groups an in the vilanterol only group (p=0·0398 for the 50 µg group, 0·0244 for the 100 µg group, and 0·0004 for the 00 µg group). In the pooled analysis, significantly fewer moderate and severe exacerbations were noted in all uticasone furoate/vilanterol groups than in the vilanterol only group (0·0141 for the 50 µg group, <0·0001 for the 100 µg group, and 0·0003 for the 200 µg group). Nasopharyngitis was the most frequently reported adverse event in both studies. Pneumonia and fractures were reported more frequently with fluticasone furoate and vilanterol than with vilanterol alone. Eight deaths from pneumonia were noted in the fluticasone furoate/vilanterol groups compared with none in the vilanterol only group.

Interpretation

Addition of fluticasone furoate to vilanterol was associated with a decreased rate of moderate and severe exacerbations of COPD in patients with a history of exacerbation, but was also associated with an increased pneumonia risk.

Funding

GlaxoSmithKline.



ČETVRTAK, 26. rujna 2013.

18.20 Svečano otvorenje i pozdravne riječi

18.30 Mini simpozij

19.20 Mini simpozij

20.00 Koktel dobrodošlice

20.20 Večera u hotelu Aurora

PETAK, 27. rujna 2013.

PLUĆNE BOLESTI UZROKOVANE LIJEKOVIMA (8.30 – 10.30)

Voditelj: J. Tekavec - Trkanjec

08.30 **J. Tekavec – Trkanjec:** UVOD. Kliničke manifestacije nuspojava lijekova u respiratornom traktu.

08.50 **N. Božina:** Farmakogenomika i nuspojave u pulmologiji.

09.10 **S. Seiwert, L. Brčić:** Patohistološke manifestacije plućnih nuspojava lijekova.

09.30 **M. Koršić, B. Čučević:** Respiratorne nuspojave onkološke terapije.

09.50 **A. Andrić:** Farmakovigilancija i prikaz respiratornih nuspojava lijekova prijavljenih HALMED-u.

10.10 Rasprava

10.30 Stanka uz kavu

FENOTIPOVI KOPB-a, KORAK DALJE OD GOLD-a? (11.00 – 12.50)

Voditelji: N. Tudorić, K. Miše

11.00 **Z. Matković:** Značaj kronične bronhalne infekcije u KOPB-u.

11.25 **N. Tudorić:** Sindrom preklapanja KOPB-a i astme.

11.50 **Ž. Vrbica:** Emfizemski fenotip KOPB-a: povratak u budućnost.

12.15 **V. Koblizek, J. Chlumsky, V. Zindr and other members of CPPS:** Chronic Obstructive Pulmonary Disease; a novel phenotypic approach to COPD with patient-oriented care

12.40 Rasprava

12.50 Mini simpozij TAKEDA

13.40 Ručak

SLOBODNE TEME (15.00 – 16.30)

Voditelji: B. Butorac - Petanjek, D. Matanić - Lender

15.00 **N. Miculinić:** Kako liječimo egzacerbacije KOPB-a u Hrvatskoj – preporuke ERS-a na temelju ERS COPD Audit studije

15.15 **Ž. Vrbica, K. Miše:** Tuđice u hrvatskoj pulmologiji

15.30 **F. Zukić:** Dijagnostika plućne embolije – CT i MRI.

16.00 **I. Aurer:** Limfomi pluća

16.30 Stanka uz kavu

MIKOBAKTERIOZE (17.00 – 18.10)

Voditelj: V. Katalinić-Janković

17.00 **E. Richter:** NTM in pulmonary infections

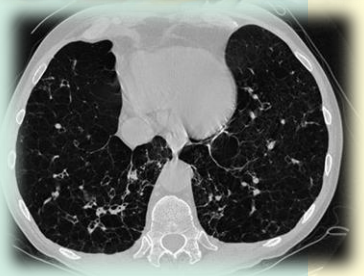
17.45 **K. Žmak:** Pojavnost i klinička značajnost NTM u Hrvatskoj

18.20 **J. Smith:** Cronic cough

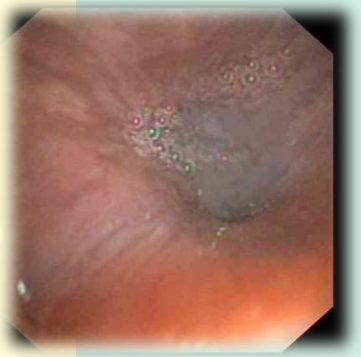
19.10 Godišnja (izborna) skupština Hrvatskog pulmološkog društva HLZ-a

20.30 Večera u hotelu Aurora

Klinické fenotypy



občasná expektorace → bronchitický fenotyp CHOPN



opakované exacerbace → fenotyp frekventní exacerbace

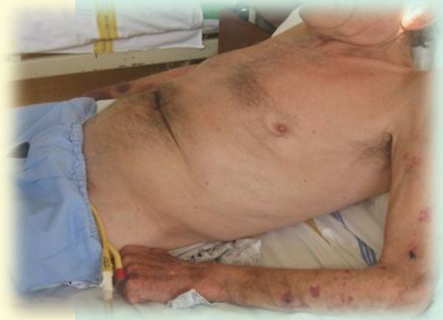
klinické rysy CHOPN i AB → fenotyp překryvu CHOPN a AB

hnisavá, každodenní expektorace → překryv CHOPN a bronchiektazií

PubMed 2013

dušnost bez expektorace → emfyzematický fenotyp

kachexie bez jiné příčiny → fenotyp plicní kachexie



Léčebná doporučení – již patrný vliv fenotypů

GOLD 2011-13
„only STRATEGY“

ERS/ATS/ACCP 2011
ERS/ATS 2005
Guidelines

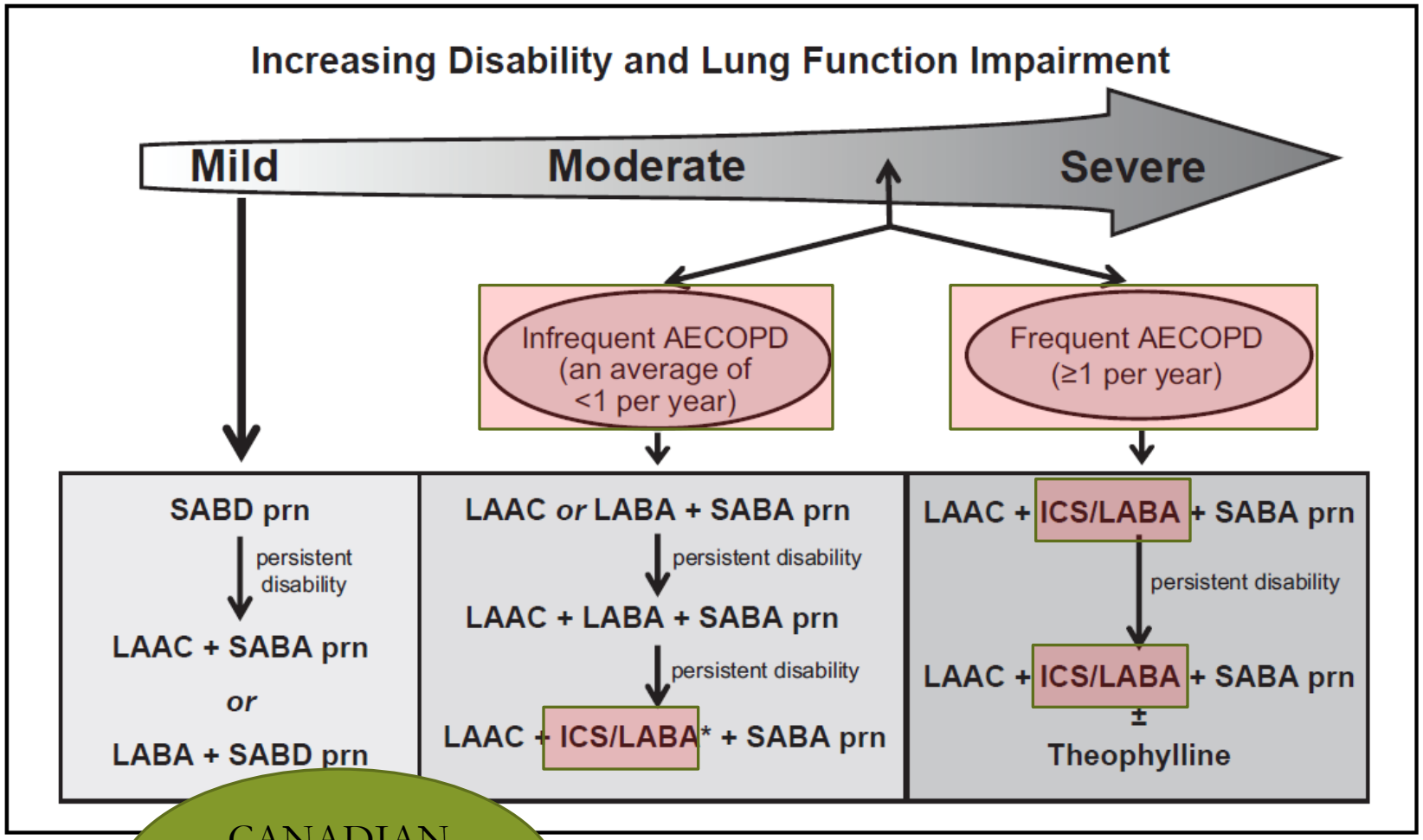
CANADIAN
2007
pre-phenotypic

CELLI 2008
REHAB +
BODE

NICE
2012,2013
EBM guidelines

SPAIN 2012
1st phenotypic
alone

Czech 2013
GOLD +
phenotypic



CANADIAN
2007
pre-phenotypic

Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease – 2007 update

Denis E O'Donnell MD[1] Chair*, Shawn Aaron MD[2]*, Jean Bourbeau MD[3]*, Paul Hernandez MD[4]*, Darcy D Marciniuk MD[5]*, Meyer Balter MD[6], Gordon Ford MD[7], Andre Gervais MD[8], Roger Goldstein MD[6], Rick Hodder MD[2], Alan Kaplan MD[9], Sean Keenan MD[10], Yves Lacasse MD[11], Francois Maltais MD[11], Jeremy Road MD[10], Graeme Rocker MD[4], Don Sin MD[10], Tasmin Sinuff MD[12], Nha Voduc MD[2]

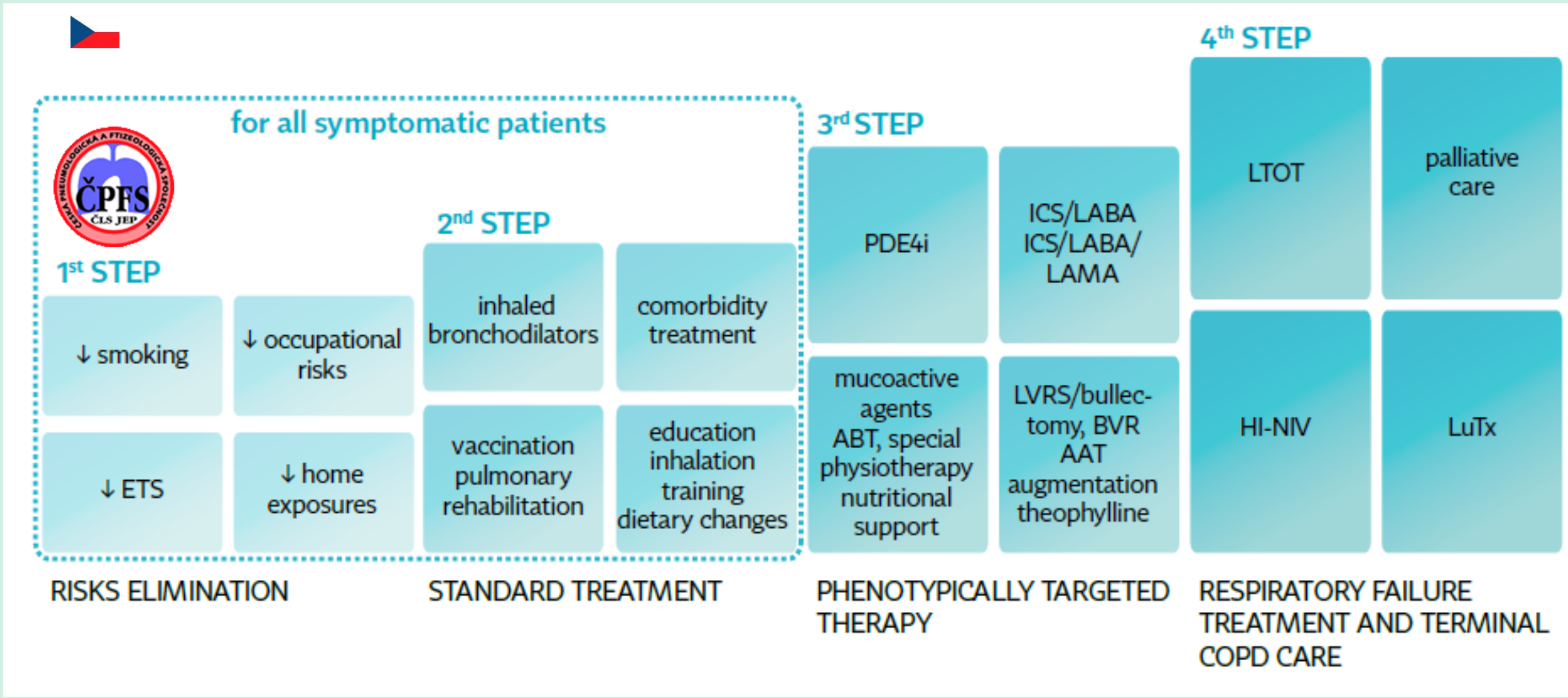
. Proposal of pharmacological treatment of COPD based on clinical phenotypes and severity

Phenotype	Severity stages I	II	III	IV
A Infrequent exacerbator	LAMA or LABA SABA or SAMA*	LAMA or LABA LAMA+ LABA	LAMA+ LABA	LAMA + LABA + theophylline
B Overlap COPD-asthma	LABA + ICS	LABA + ICS	LAMA + LABA + ICS	LAMA + LABA +ICS (consider adding theophylline or PDE4I if there is expectoration)
C Exacerbator with emphysema	LAMA or LABA	(LABA or LAMA) + ICS LAMA + LABA LAMA or LABA	LAMA + LABA + CI	LAMA + LABA + ICS (consider adding theophylline)
D Exacerbator with chronic bronchitis	LAMA or LABA	(LAMA or LABA) + (ICS or PDE4I) LAMA + LABA LAMA or LABA	LAMA + LABA + (ICS or PDE4I) (LAMA or LABA) + ICS + PDE4I (consider adding carbocisteine)	LAMA + LABA + (ICS or PDE4I) LAMA + LABA + ICS + PDE4I (consider adding carbocisteine) (consider adding theophylline) (consider adding antibiotics)

Reproduced with permission from Soriano *et al*.[3]

ICS=inhaled corticosteroids; LAMA=long-acting anticholinergic; LABA=long-acti… PDE4I=phosphodiesterase 4 inhibitor; SABA=short-acting β_2-agonist; SAMA=short-acting anticholinergic. *In case of intermittent symptom…

SPAIN 2012
1st phenotypic
alone


for all symptomatic patients
ČPFS
ČLS JEP
1st STEP
↓ smoking
↓ occupational risks
↓ ETS
↓ home exposures
2nd STEP
inhaled bronchodilators
comorbidity treatment
vaccination pulmonary rehabilitation
education inhalation training dietary changes
3rd STEP
PDE4i
ICS/LABA
ICS/LABA/ LAMA
mucoactive agents ABT, special physiotherapy nutritional support
LVRS/bullec-tomy, BVR AAT augmentation theophylline
4th STEP
LTOT
palliative care
HI-NIV
LuTx
RISKS ELIMINATION
STANDARD TREATMENT
PHENOTYPICALLY TARGETED THERAPY
RESPIRATORY FAILURE TREATMENT AND TERMINAL COPD CARE

Fenotyp bronchitický

- přítomnost produktivního kašle (>3 měsíce/rok, v posledních nejméně 2 letech)

Fenotyp emfyzematický

- celoživotní nepřítomnost produktivního kašle (suchý kašel může být přítomen), současně (dle HRCT a TLCO) známky plicního emfyzému

Fenotyp CHOPN a bronchiektázií

- akcentovaná každodenní, expektorace, mladší věk, nekuřáci, prolongované infekce plic a DDC, hemoptýzy, HRCT známky bronchiektázií

Fenotyp overlapu CHOPN s bronchiálním astmatem
(2 hlavní a 1 hlavní + 2 vedlejší kritéria)

- hlavní kritéria: (a) výrazně pozitivní BDT (vzestup FEV_1 >15 % a >400 ml) (b) pozitivní BKT, (c) ↑FENO (≥45-50 ppb) a/nebo ↑eo ve sputu (≥3 %) (d) AB v anamnéze
- vedlejší kritéria: (a) pozitivní BDT (vzestup FEV_1 >12 % a >200 ml) (b) ↑celkové IgE (c) atopická anamnéza

Fenotyp frekventní exacerbace

- přítomnost častých akutních exacerbací (≥2/rok) léčených ATB a/nebo systémovými kortikosteroidy

Fenotyp plicní kachexie

- FFMI < 16 kg/m² (muži), FFMI < 15 kg/m² (ženy), případně BMI < 21 kg/m² (nezávisle na pohlaví) - bez jiné zjevné příčiny

Jak na to ?

Nástroje na určení fenotypů

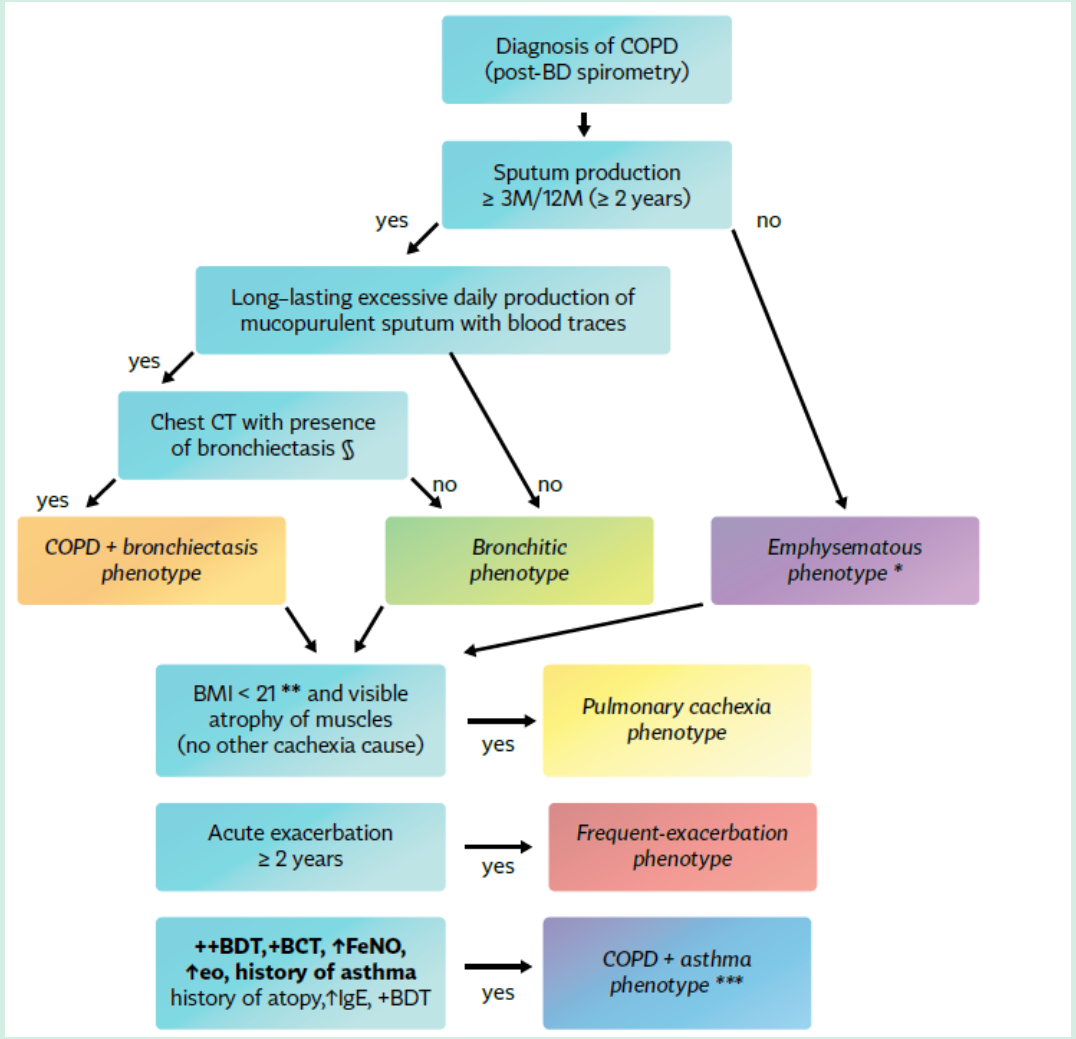
Anamnéza *(AE, vykašlávání hlenu, hnisu + krve, atopie)*

Výsledky *(BDT, BKT, FeNO, IgE)*

Vyšetření *(BMI, atrofie svalů)*

Funkční *(RV + TL_{CO}, K_{CO})*

CT hrudníku *(EMFYZ./BRONCHIEKTAZIE)*



Česká data

Kolik máme exacerbačních CHOPN ?

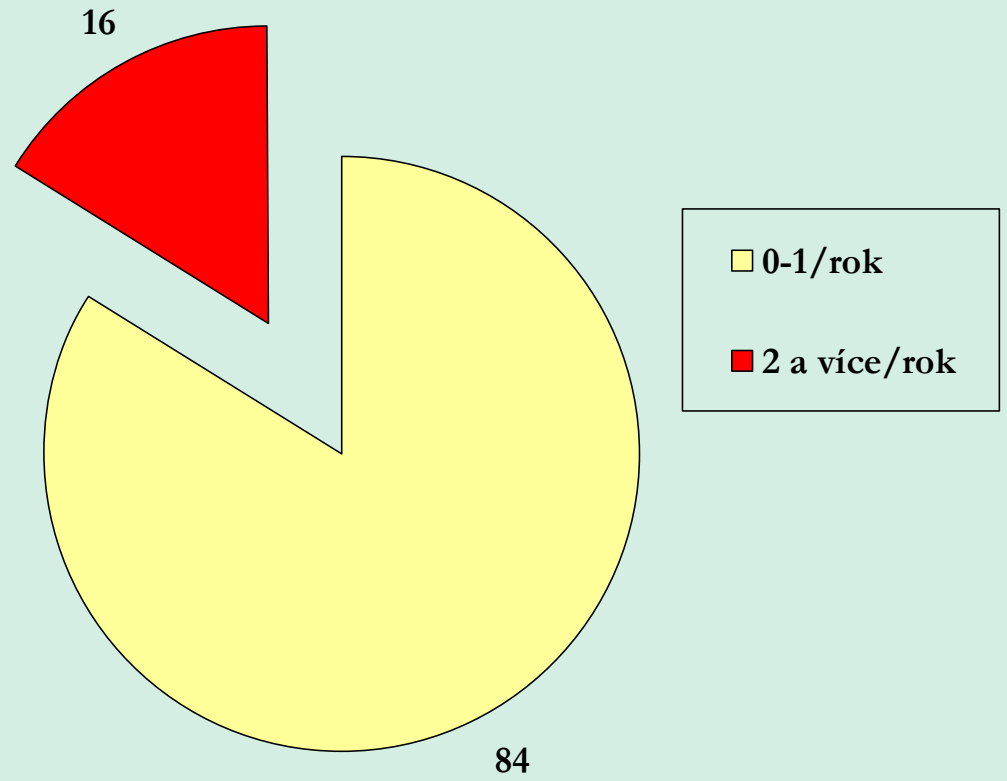
FN HK n 100

Karlovy Vary n 99

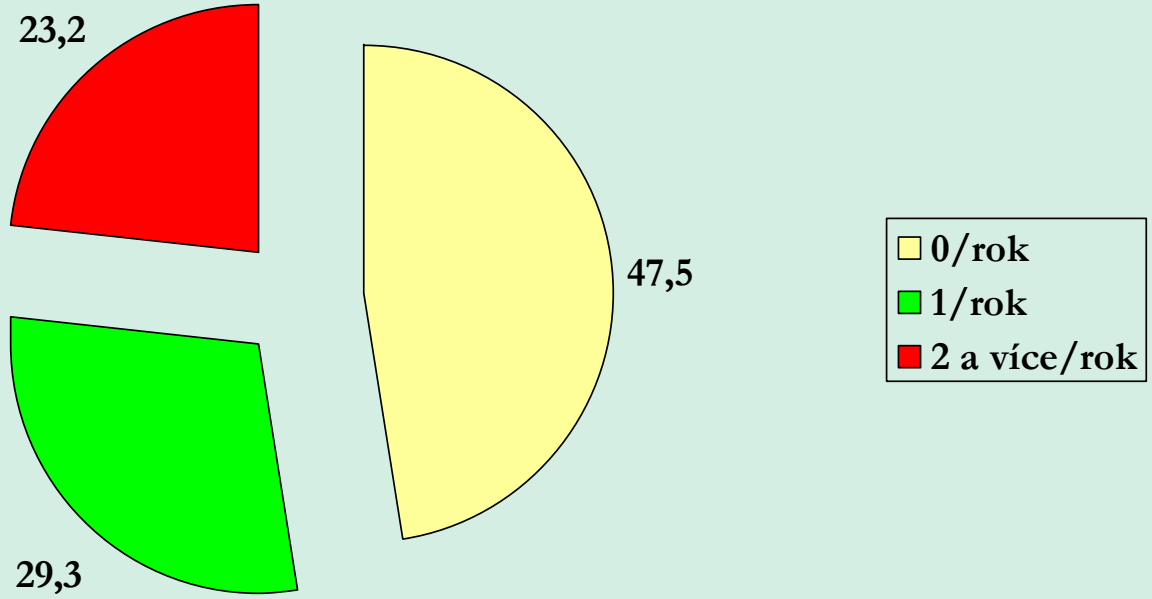
0/rok
1/rok
2 a více/rok

Mr.CAT Study

Kolik máme exacerbačních CHOPN ?



FN HK n 100



Karlovy Vary n 99

Mr.CAT Study

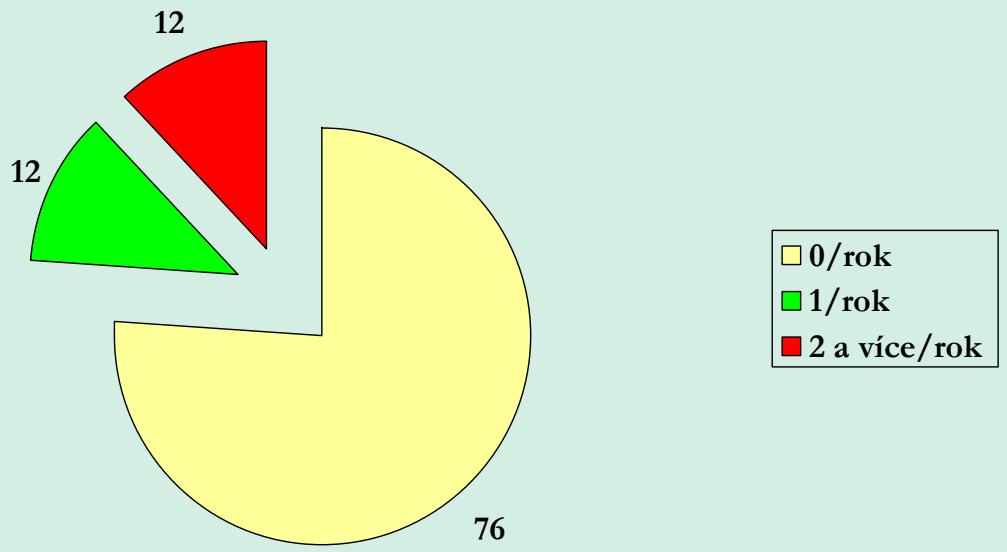
Kolik máme exacerbačních CHOPN?

Teplice n 25

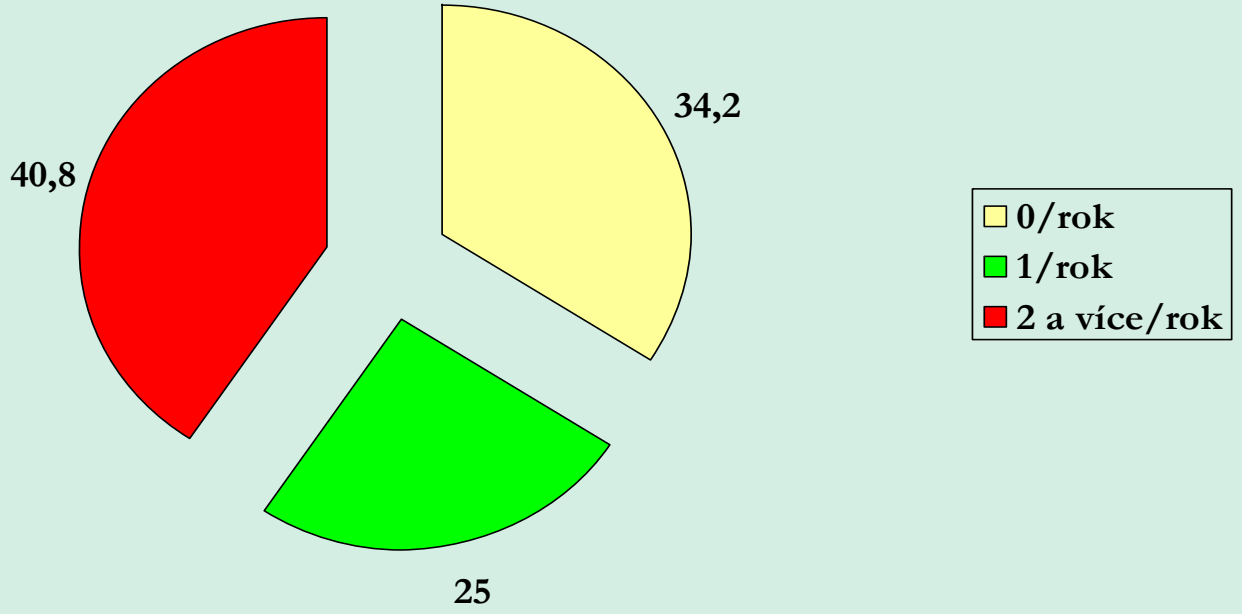
Ostrava n 76

Mr.CAT Study

Kolik máme exacerbačních CHOPN?



Teplice n 25



Ostrava n 76

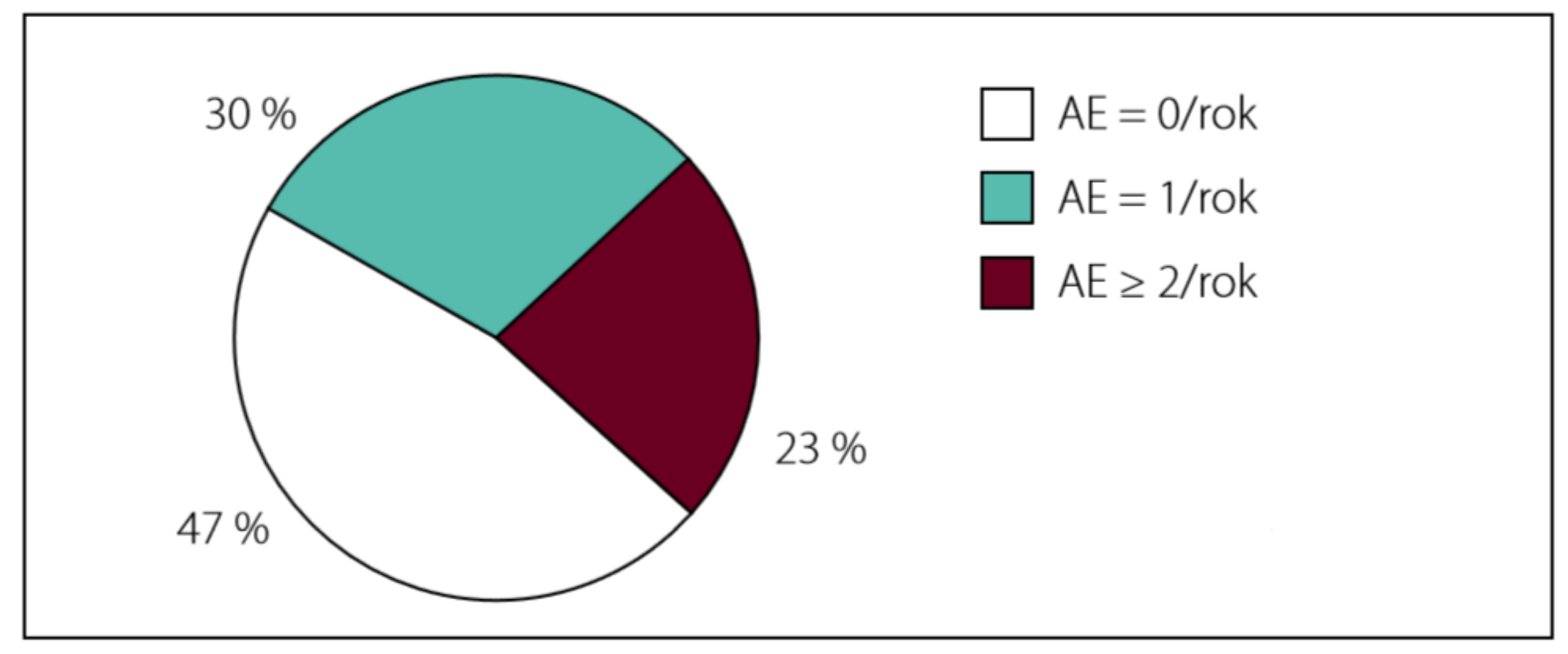
Mr.CAT Study

Kolik máme exacerbačních CHOPN ?

ČR n 1355

CEEOR Study

Kolik máme exacerbačních CHOPN ?



ČR n 1355

CEEOR Study

Ambulance – Holice (privátní praxe)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	nevyhraněný	8
GOLD 1	1 A	bronchitický	2
GOLD 2	2 A	nevyhraněný	2
GOLD 2	2 A	bronchitický	6
GOLD 2	2 B	bronchitický	2
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	overlap s astmatem	2
GOLD 3	3 D	bronchitický	4
GOLD 3	3 D	bronchitický + emfyzematický	1
GOLD 3	3 D	bronchitický + bronchiektazie	1
GOLD 3	3 D	overlap s astmatem	1
GOLD 4	4 C	bronchitický	1
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický + emfyzematický	3
GOLD 4	4 D	bronchitický	2
GOLD 4	4 D	overlap s astmatem	2
GOLD 4	4 D	bronchitický + exacerbační	1

N 40 pacientů

Ambulance – Holice (privátní praxe)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	nevyhraněný	8
GOLD 1	1 A	bronchitický	2
GOLD 2	2 A	nevyhraněný	2
GOLD 2	2 A	bronchitický	6
GOLD 2	2 B	bronchitický	2
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	overlap s astmatem	2
GOLD 3	3 D	bronchitický	4
GOLD 3	3 D	bronchitický + emfyzematický	1
GOLD 3	3 D	bronchitický + bronchiektazie	1
GOLD 3	3 D	overlap s astmatem	1
GOLD 4	4 C	bronchitický	1
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický + emfyzematický	3
GOLD 4	4 D	bronchitický	2
GOLD 4	4 D	overlap s astmatem	2
GOLD 4	4 D	bronchitický + exacerbační	1

N 40 pacientů

Ambulance – Holice (privátní praxe)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	nevyhraněný	8
GOLD 1	1 A	bronchitický	2
GOLD 2	2 A	nevyhraněný	2
GOLD 2	2 A	bronchitický	6
GOLD 2	2 B	bronchitický	2
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	overlap s astmatem	2
GOLD 3	3 D	bronchitický	4
GOLD 3	3 D	bronchitický + emfyzematický	1
GOLD 3	3 D	bronchitický + bronchiektazie	1
GOLD 3	3 D	overlap s astmatem	1
GOLD 4	4 C	bronchitický	1
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický + emfyzematický	3
GOLD 4	4 D	bronchitický	2
GOLD 4	4 D	overlap s astmatem	2
GOLD 4	4 D	bronchitický + exacerbační	1

N 40 pacientů

Ambulance – Holice (privátní praxe)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	nevyhraněný	8
GOLD 1	1 A	bronchitický	2
GOLD 2	2 A	nevyhraněný	2
GOLD 2	2 A	bronchitický	6
GOLD 2	2 B	bronchitický	2
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	overlap s astmatem	2
GOLD 3	3 D	bronchitický	4
GOLD 3	3 D	bronchitický + emfyzematický	1
GOLD 3	3 D	bronchitický + bronchiektazie	1
GOLD 3	3 D	overlap s astmatem	1
GOLD 4	4 C	bronchitický	1
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický + emfyzematický	3
GOLD 4	4 D	bronchitický	2
GOLD 4	4 D	overlap s astmatem	2
GOLD 4	4 D	bronchitický + exacerbační	1

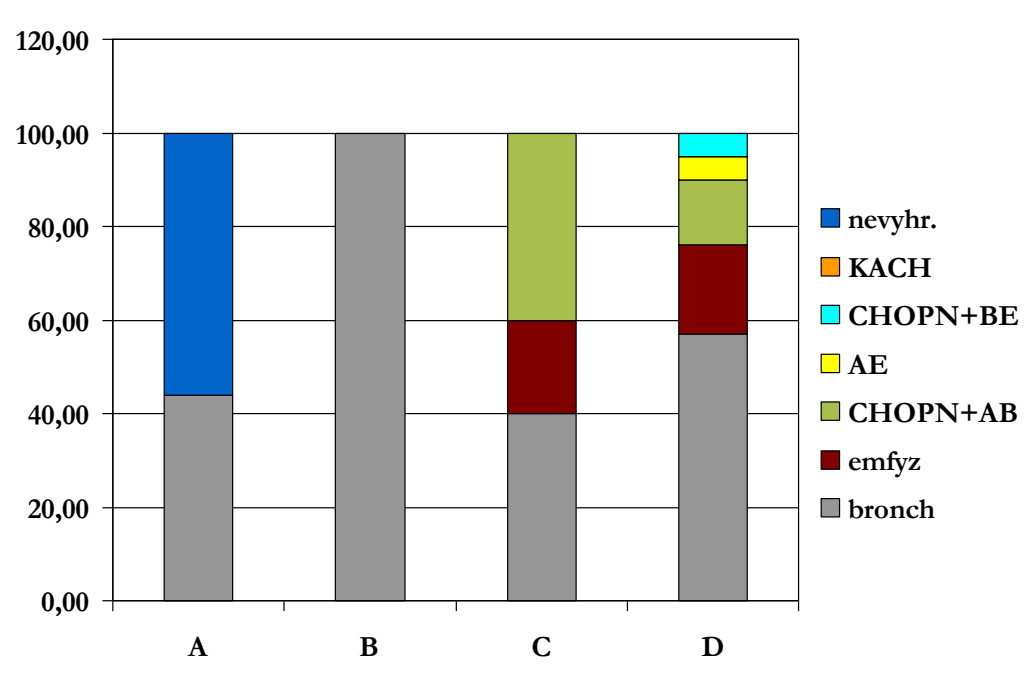
N 40 pacientů

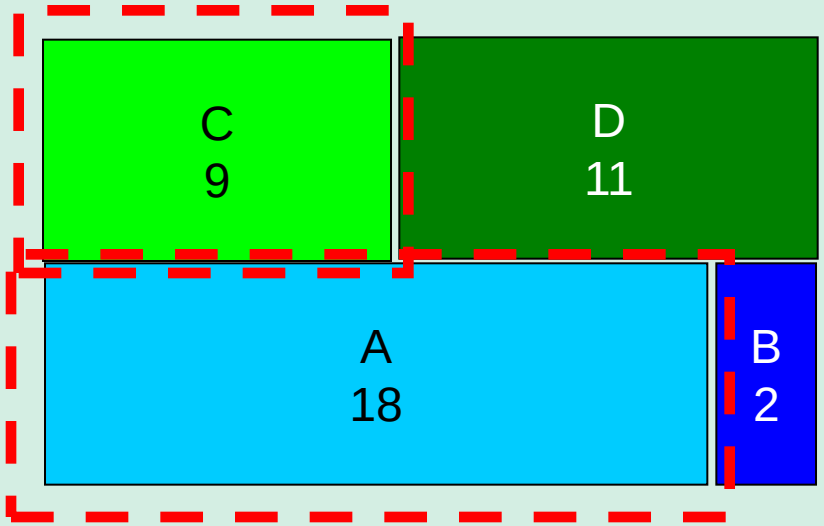
Ambulance – Holice (privátní praxe)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	nevyhraněný	8
GOLD 1	1 A	bronchitický	2
GOLD 2	2 A	nevyhraněný	2
GOLD 2	2 A	bronchitický	6
GOLD 2	2 B	bronchitický	2
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	overlap s astmatem	2
GOLD 3	3 D	bronchitický	4
GOLD 3	3 D	bronchitický + emfyzematický	1
GOLD 3	3 D	bronchitický + bronchiektazie	1
GOLD 3	3 D	overlap s astmatem	1
GOLD 4	4 C	bronchitický	1
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický + emfyzematický	3
GOLD 4	4 D	bronchitický	2
GOLD 4	4 D	overlap s astmatem	2
GOLD 4	4 D	bronchitický + exacerbační	1

N 40 pacientů

Ambulance – Holice (privátní praxe)





N 40 pacientů

Ambulance – Nový Jičín (nemocnice)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	overlap s astmatem	3
GOLD 1	1 B	overlap s astmatem	3
GOLD 1	1 A	bronchitický	1
GOLD	1 B	bronchitický	1
GOLD 1	1 B	overlap s astmatem + BE + emfyzemat.	1
GOLD 1	1 C	overlap s astmatem	1
GOLD 2	2 A	bronchitický	4
GOLD 2	2 B	overlap s astmatem	3
GOLD 2	2 B	bronchitický	2
GOLD 2	2 D	overlap s astmatem + AE	1
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	BE	1
GOLD 3	3 C	emfyzematický	1
GOLD 3	3 D	bronchitický	2
GOLD 3	3 D	bronchitický + AE	2
GOLD 3	3 D	AE	2
GOLD 3	3 D	emfyzematický	1
GOLD 4	4 C	bronchitický	2
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický	3
GOLD 4	4 D	emfyzematický + kachexie	2
GOLD 4	4 D	emfyzematický + AE	1
GOLD 4	4 D	overlap s astmatem + AE + BE	1

N 40 pacientů

Ambulance – Nový Jičín (nemocnice)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	overlap s astmatem	3
GOLD 1	1 B	overlap s astmatem	3
GOLD 1	1 A	bronchitický	1
GOLD	1 B	bronchitický	1
GOLD 1	1 B	overlap s astmatem + BE + emfyzemat.	1
GOLD 1	1 C	overlap s astmatem	1
GOLD 2	2 A	bronchitický	4
GOLD 2	2 B	overlap s astmatem	3
GOLD 2	2 B	bronchitický	2
GOLD 2	2 D	overlap s astmatem + AE	1
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	BE	1
GOLD 3	3 C	emfyzematický	1
GOLD 3	3 D	bronchitický	2
GOLD 3	3 D	bronchitický + AE	2
GOLD 3	3 D	AE	2
GOLD 3	3 D	emfyzematický	1
GOLD 4	4 C	bronchitický	2
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický	3
GOLD 4	4 D	emfyzematický + kachexie	2
GOLD 4	4 D	emfyzematický + AE	1
GOLD 4	4 D	overlap s astmatem + AE + BE	1

N 40 pacientů

Ambulance – Nový Jičín (nemocnice)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	overlap s astmatem	3
GOLD 1	1 B	overlap s astmatem	3
GOLD 1	1 A	bronchitický	1
GOLD	1 B	bronchitický	1
GOLD 1	1 B	overlap s astmatem + BE + emfyzemat.	1
GOLD 1	1 C	overlap s astmatem	1
GOLD 2	2 A	bronchitický	4
GOLD 2	2 B	overlap s astmatem	3
GOLD 2	2 B	bronchitický	2
GOLD 2	2 D	overlap s astmatem + AE	1
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	BE	1
GOLD 3	3 C	emfyzematický	1
GOLD 3	3 D	bronchitický	2
GOLD 3	3 D	bronchitický + AE	2
GOLD 3	3 D	AE	2
GOLD 3	3 D	emfyzematický	1
GOLD 4	4 C	bronchitický	2
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický	3
GOLD 4	4 D	emfyzematický + kachexie	2
GOLD 4	4 D	emfyzematický + AE	1
GOLD 4	4 D	overlap s astmatem + AE + BE	1

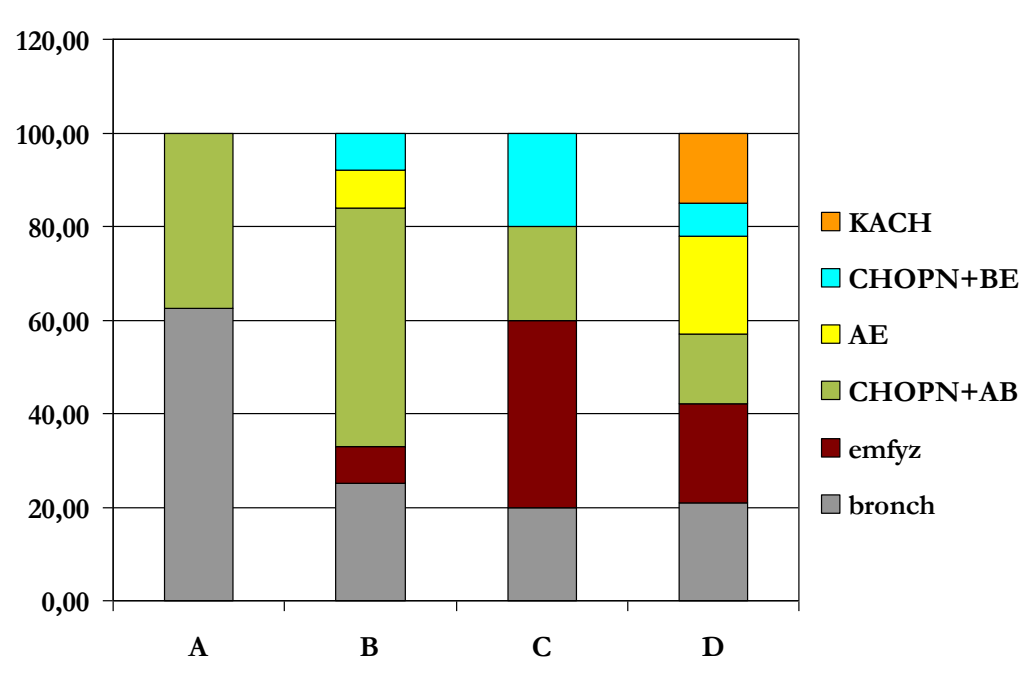
N 40 pacientů

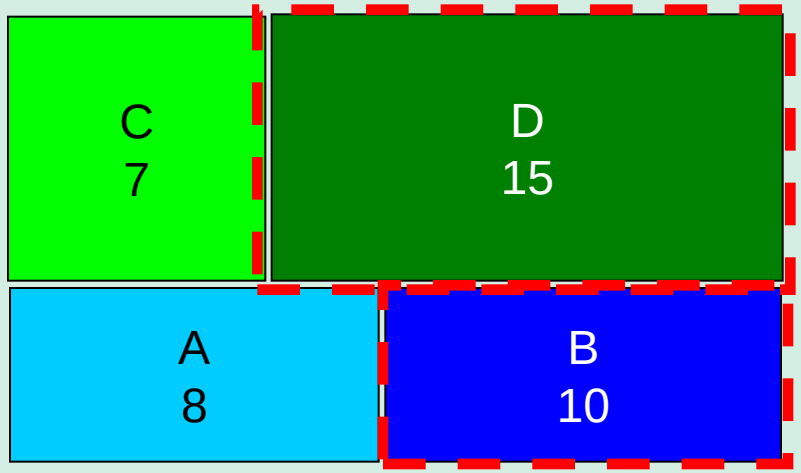
Ambulance – Nový Jičín (nemocnice)

GOLD	Kategorie	Fenotyp	Počet nemocných
GOLD 1	1 A	overlap s astmatem	3
GOLD 1	1 B	overlap s astmatem	3
GOLD 1	1 A	bronchitický	1
GOLD	1 B	bronchitický	1
GOLD 1	1 B	overlap s astmatem + BE + emfyzemat.	1
GOLD 1	1 C	overlap s astmatem	1
GOLD 2	2 A	bronchitický	4
GOLD 2	2 B	overlap s astmatem	3
GOLD 2	2 B	bronchitický	2
GOLD 2	2 D	overlap s astmatem + AE	1
GOLD 3	3 C	bronchitický	1
GOLD 3	3 C	BE	1
GOLD 3	3 C	emfyzematický	1
GOLD 3	3 D	bronchitický	2
GOLD 3	3 D	bronchitický + AE	2
GOLD 3	3 D	AE	2
GOLD 3	3 D	emfyzematický	1
GOLD 4	4 C	bronchitický	2
GOLD 4	4 C	emfyzematický	1
GOLD 4	4 D	bronchitický	3
GOLD 4	4 D	emfyzematický + kachexie	2
GOLD 4	4 D	emfyzematický + AE	1
GOLD 4	4 D	overlap s astmatem + AE + BE	1

N 40 pacientů

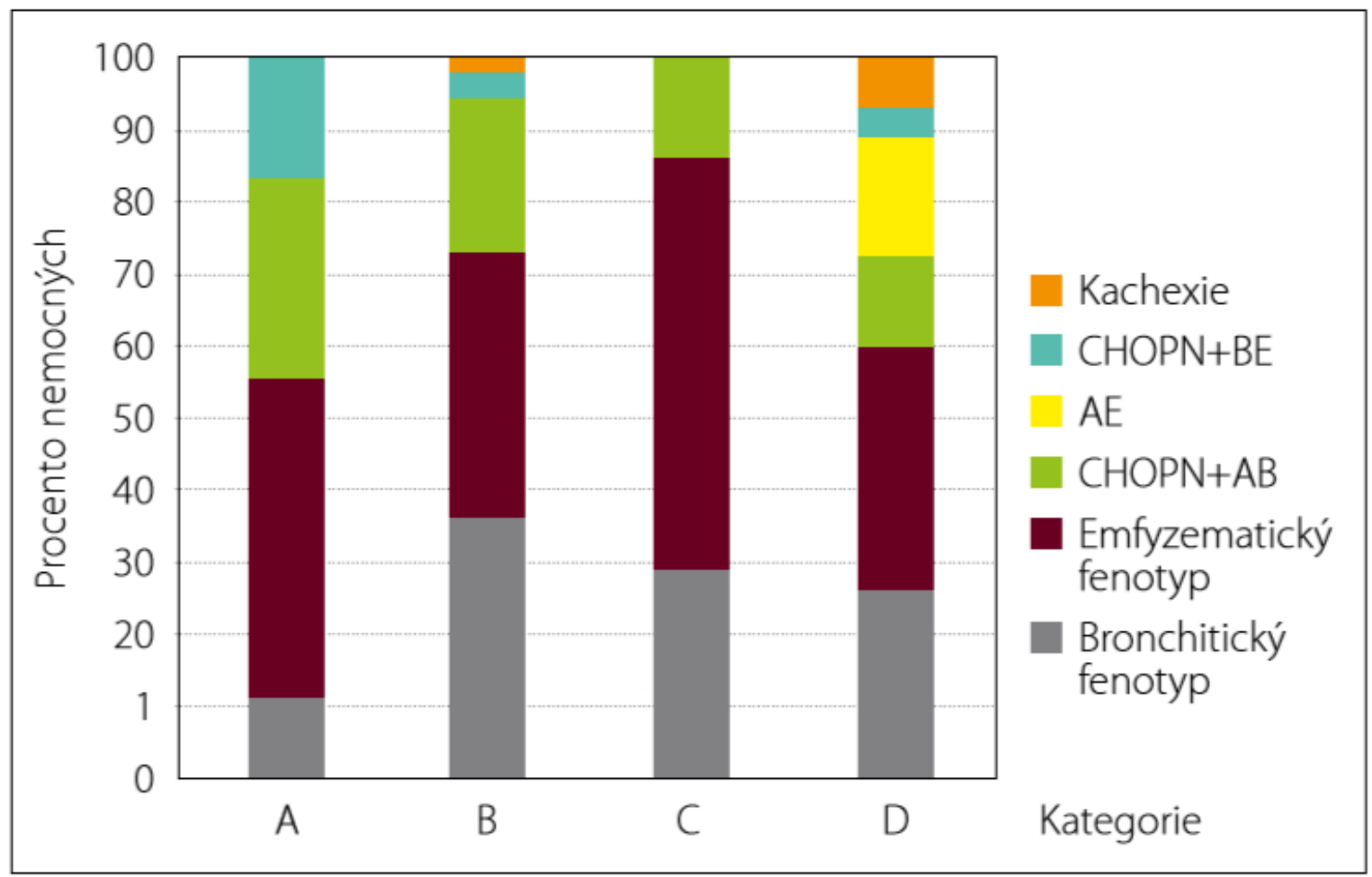
Ambulance – Nový Jičín (nemocnice)





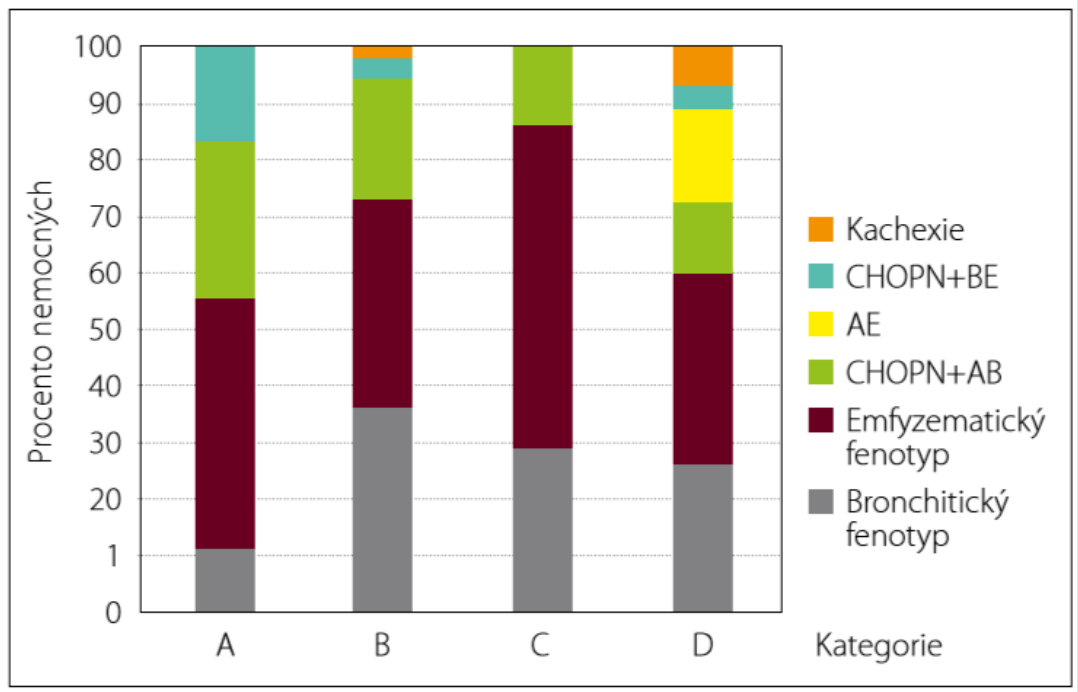
N 40 pacientů

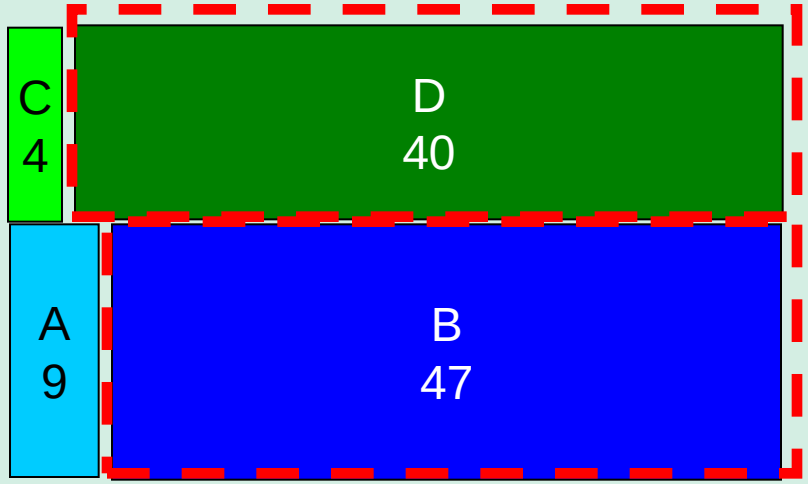
Ambulance – Hradec Králové (FN)



N 100 pacientů

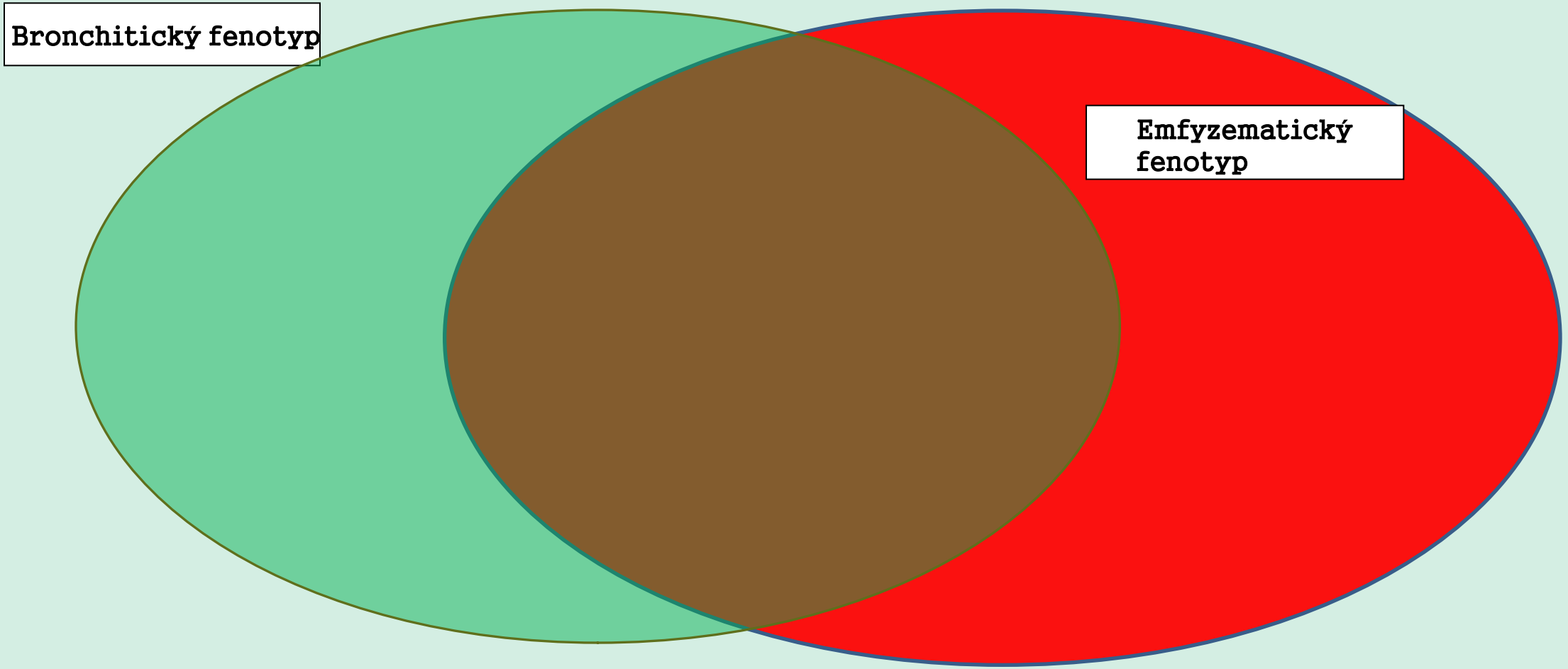
Ambulance – Hradec Králové (FN)





N 100 pacientů

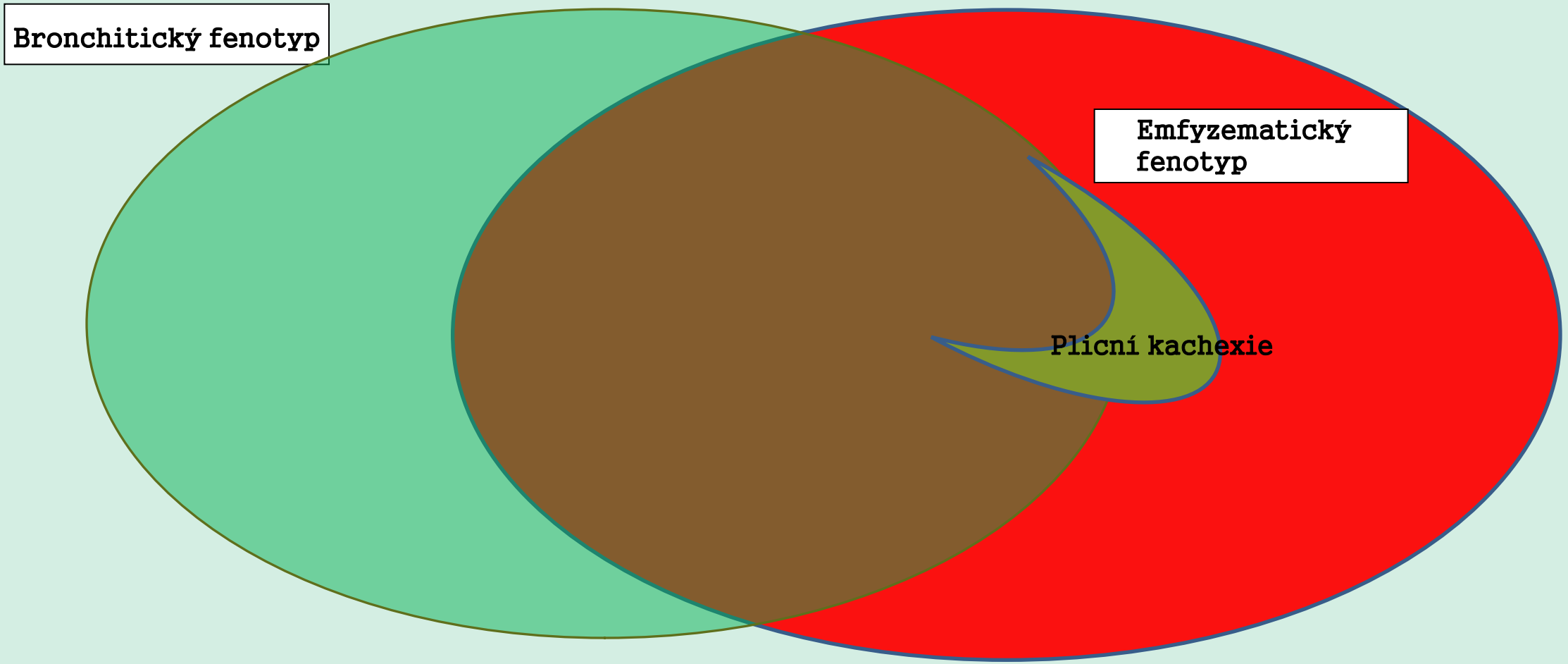
Překryv fenotypů



N 100 pacientů

Koblizek, Pracharova Preliminary results - Mr.CAT Study

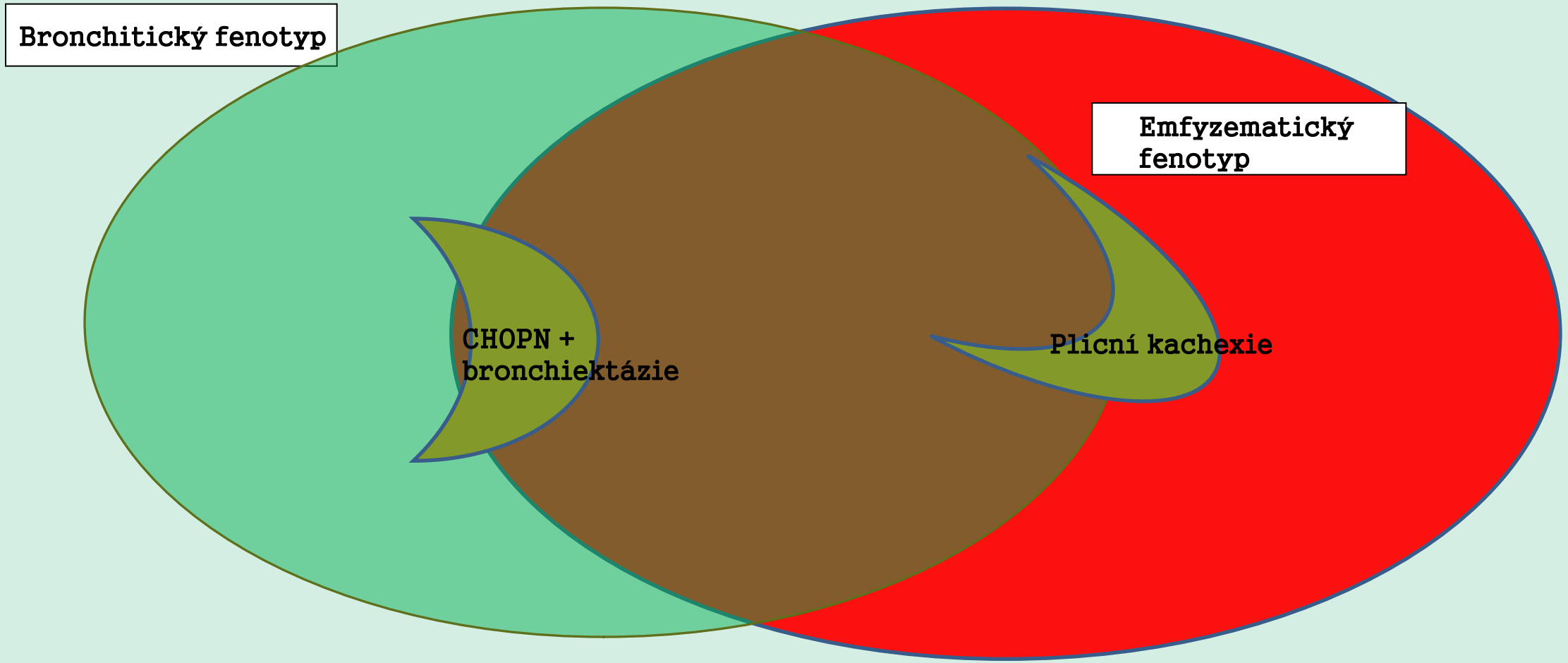
Překryv fenotypů



N 100 pacientů

Koblizek, Pracharova Preliminary results - Mr.CAT Study

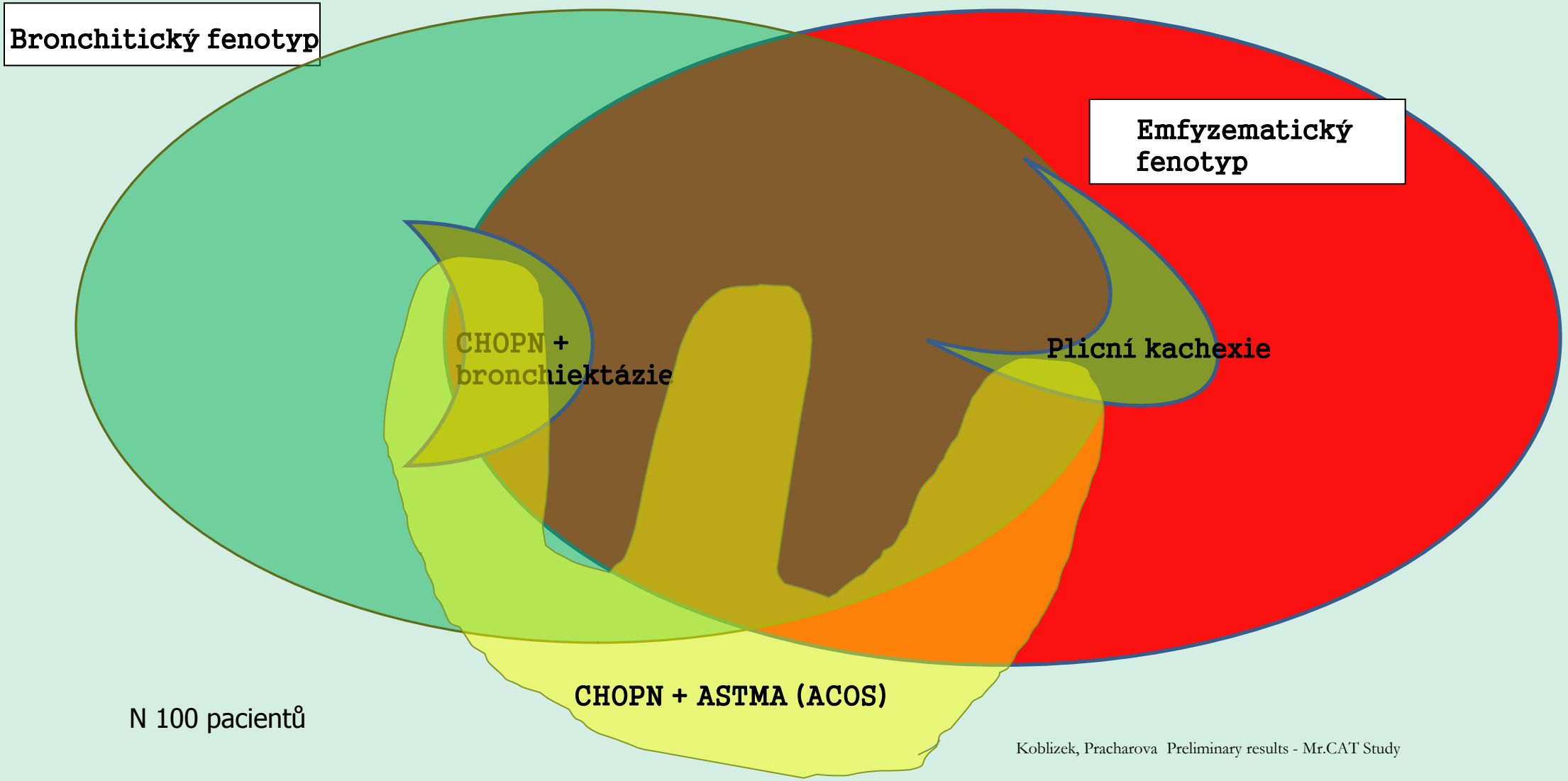
Překryv fenotypů



N 100 pacientů

Koblizek, Pracharova Preliminary results - Mr.CAT Study

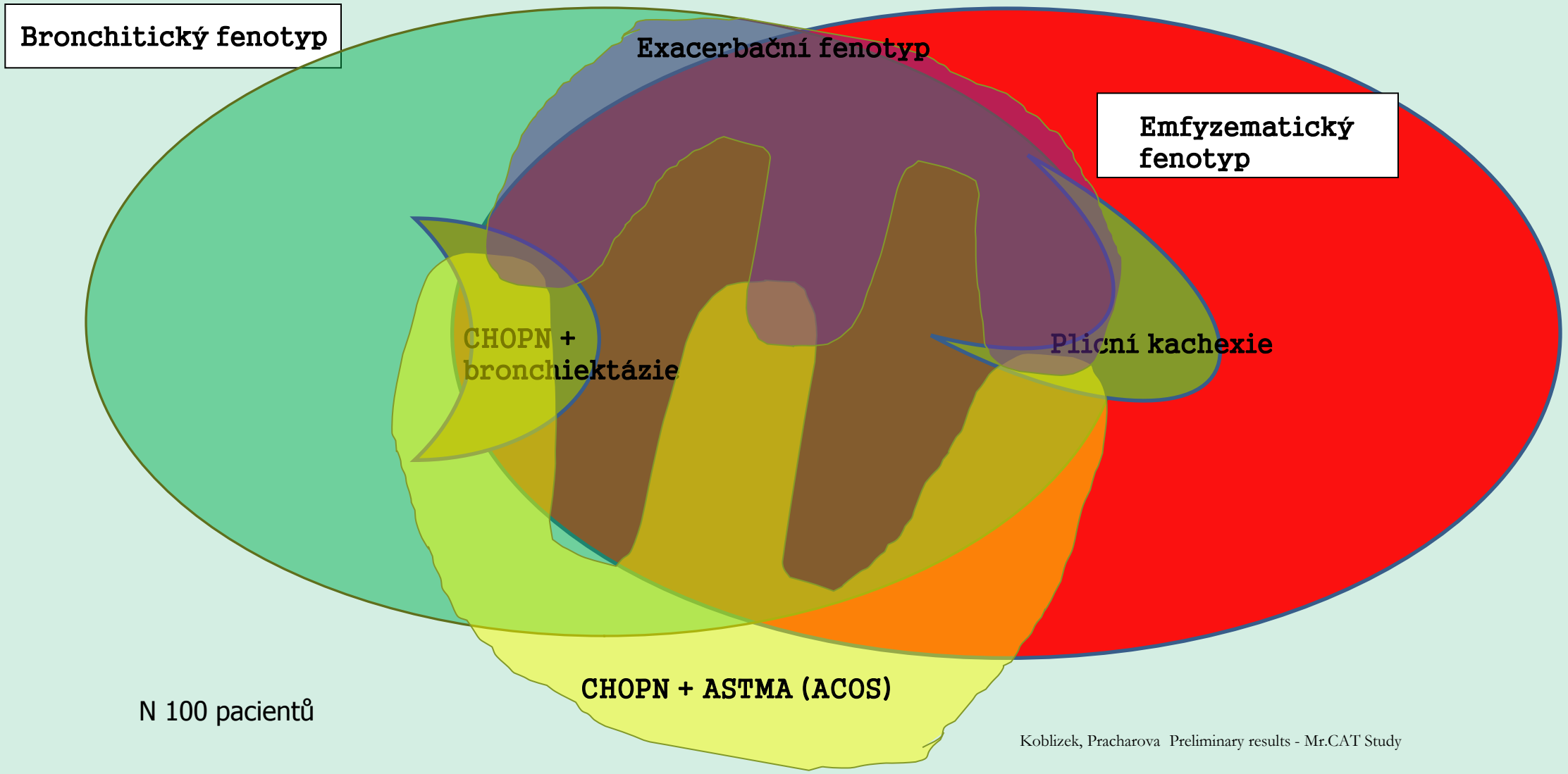
Překryv fenotypů



N 100 pacientů

Koblizek, Pracharova Preliminary results - Mr.CAT Study

Překryv fenotypů



N 100 pacientů

Koblizek, Pracharova Preliminary results - Mr.CAT Study

Frekvence výskytu fenotypů (%)

- **Kachexie 9 %**
- **CHOPN + bronchiektazie 10%**

- **Exacerbační fenotyp 16%**
- **CHOPN + astma 37%**

- **Bronchitický 62% (40%)**
- **Emfyzematický 78% (40%)**

Koblizek, Zindr, Kocianova – Mr.CAT Study

Frekvence výskytu fenotypů (%)

- **Kachexie 9 %**
- **CHOPN + bronchiektazie 10%**

- **Exacerbační fenotyp 16%**
- **CHOPN + astma 37%**

- **Bronchitický 62% (40%)**
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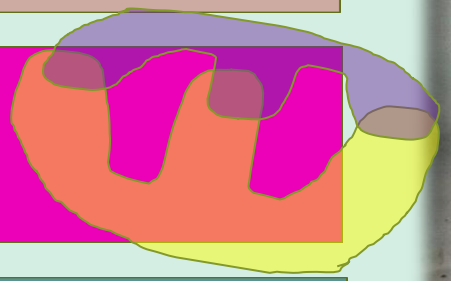
Koblizek, Zindr, Kocianova – Mr.CAT Study

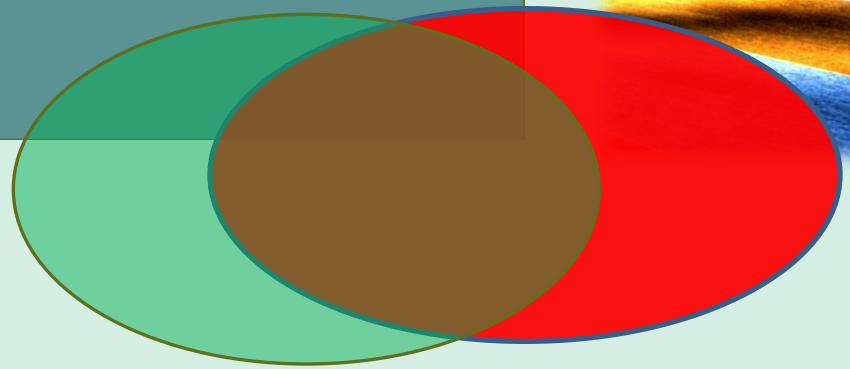
Frekvence výskytu fenotypů (%)

- Kachexie 9 %
- CHOPN + bronchiektazie 10%

- Exacerbační fenotyp 16%
- CHOPN + astma 37%



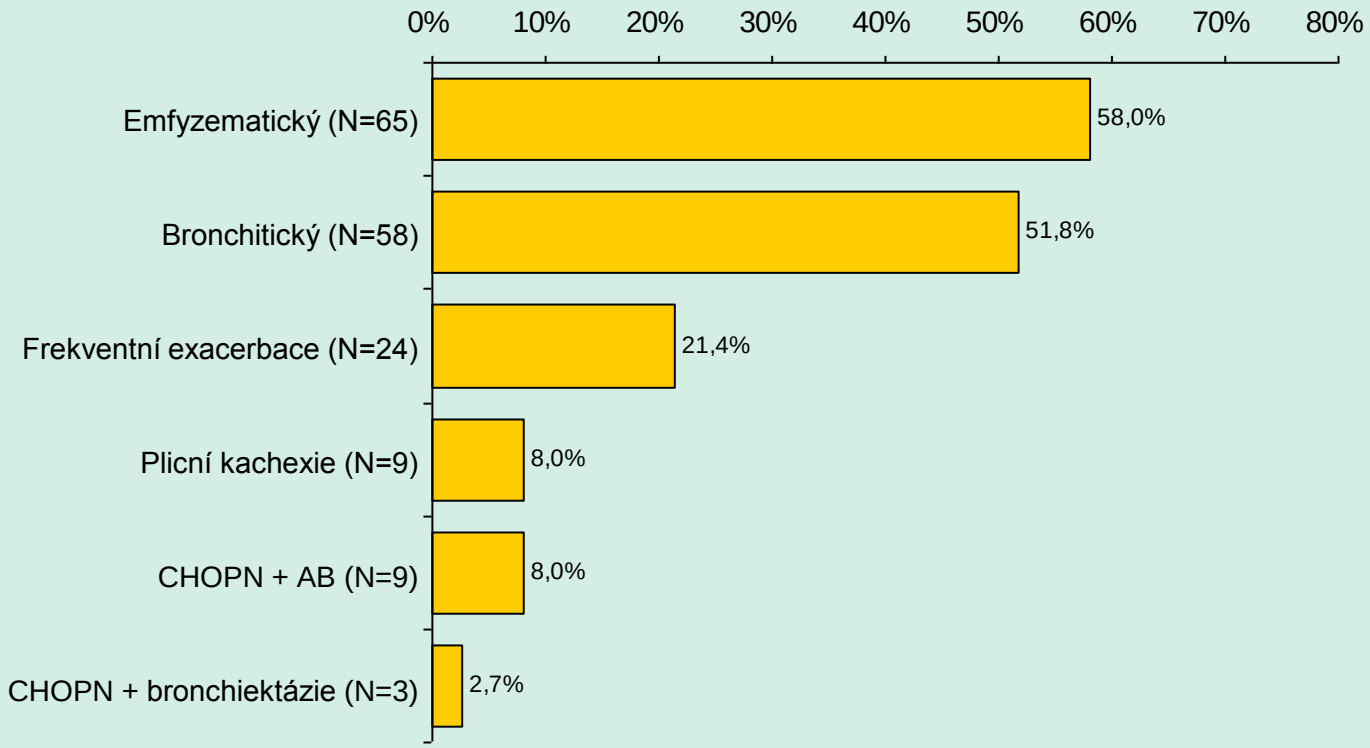
- Bronchitický 62% (40%)
- Emfyzematický 78% (40%)



Koblizek, Zindr, Kocianova – Mr.CAT Study

Fenotyp CHOPN (dominantní, hodnoceno lékařem)

N=112



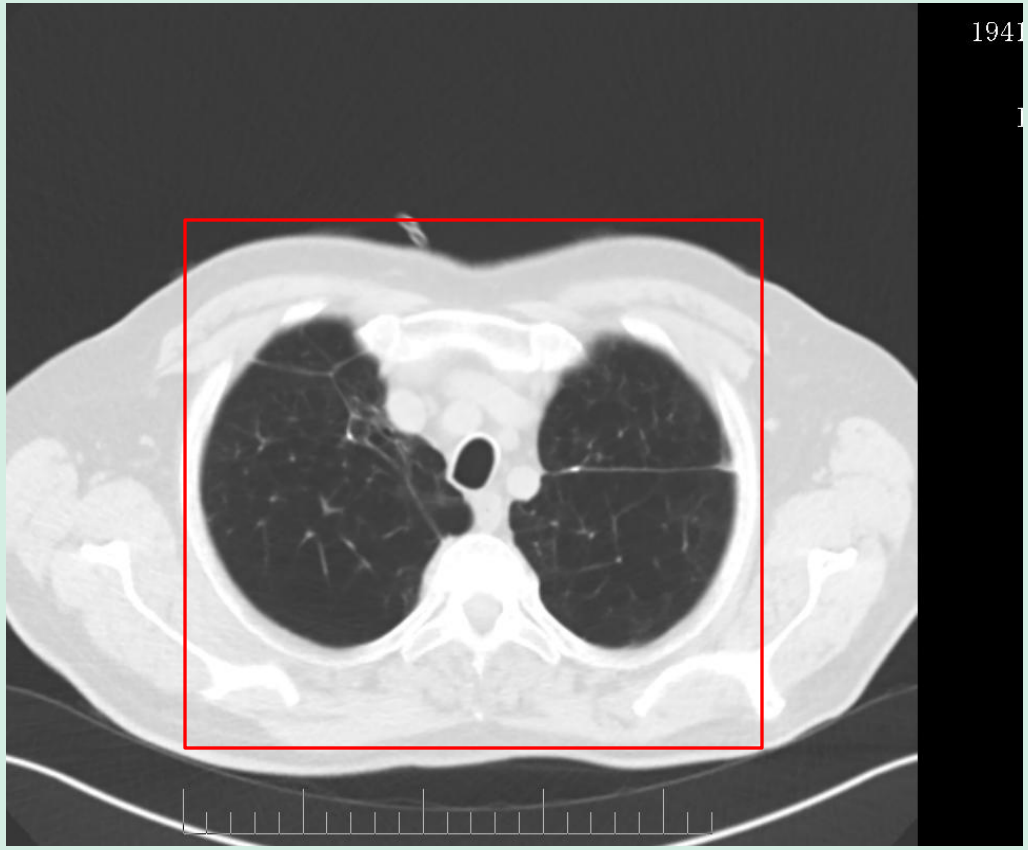
Dominantní fenotyp CHOPN – REGISTR těžkého CHOPN 2013

Souhrn

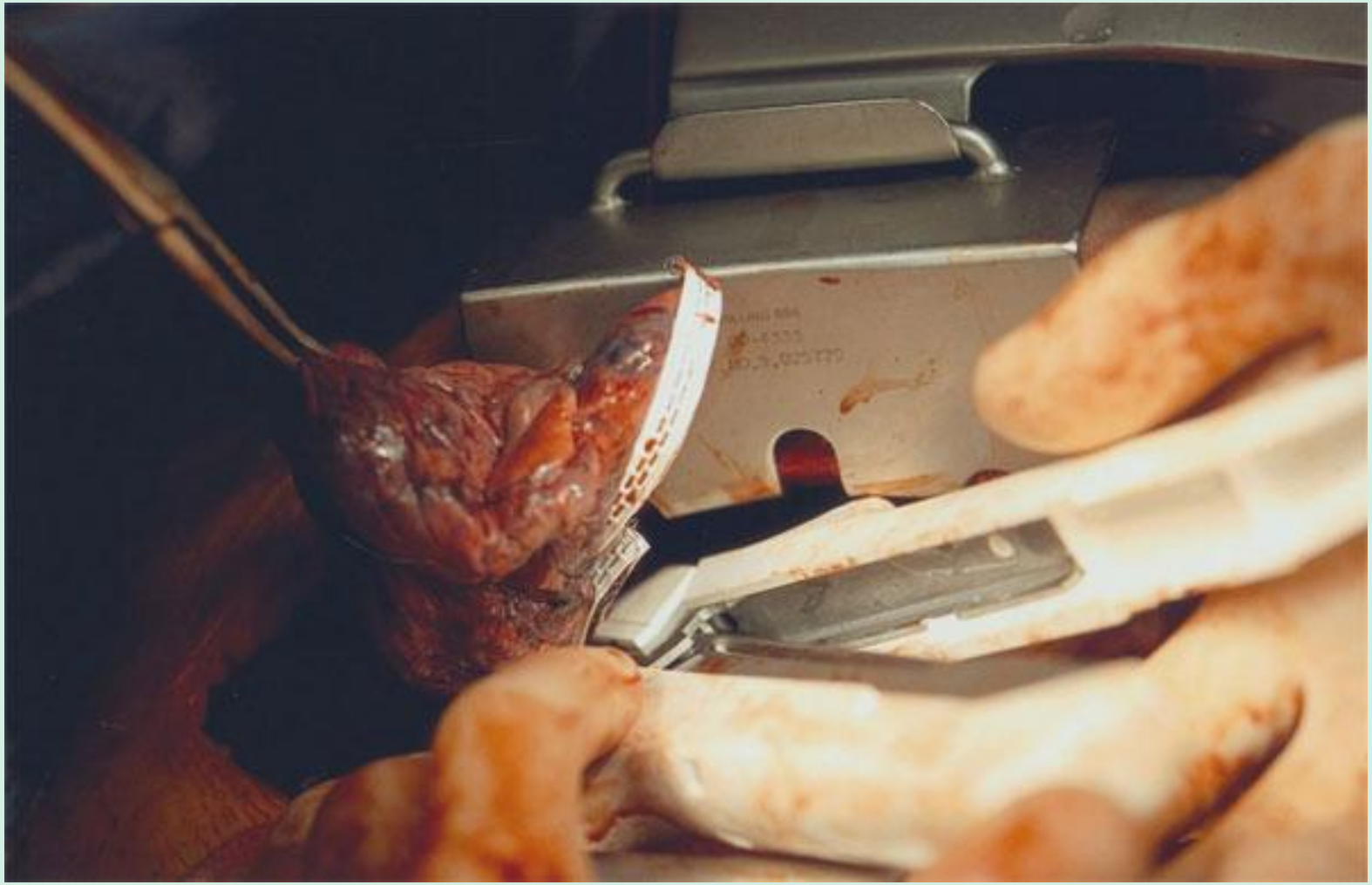
- Fenotypy se vyskytují v reálné klinické praxi
- Jejich identifikace je možná ve všech typech ambulancí
- Mohou ukázat na specifické léčebné možnosti

- Optimální nástroje k jejich vyhledávání ?
- Vývoj fenotypů v čase ?
- Prognostický význam ?

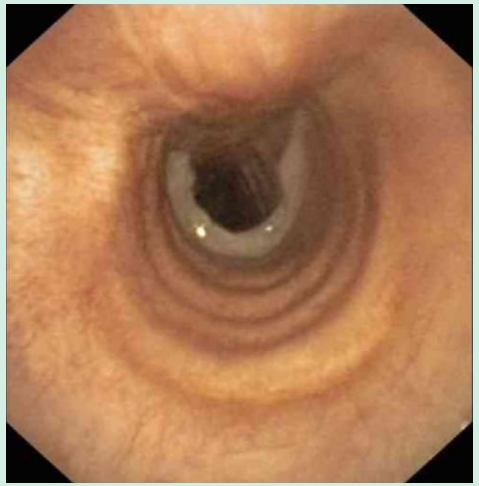
Klinický příklad I

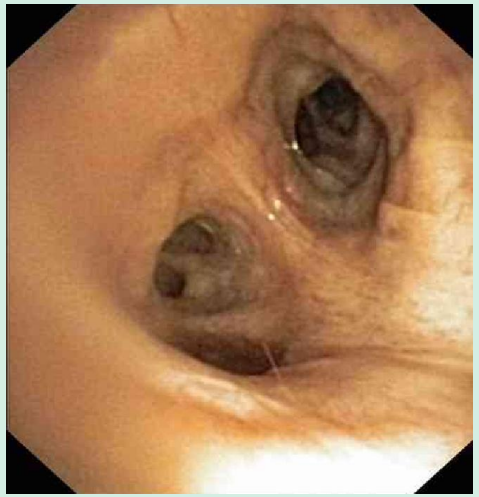


2005 – IV.CHOPN, PaO_2 7,5, FEV_1 32%, TLCO 32%, mMRC 2-3, 6MWD 350m
2006 – LVRS (bilaterálně, VTS) po 2M PaO_2 8,25, FEV1 41%, mMRC 2, 6MWD 385m

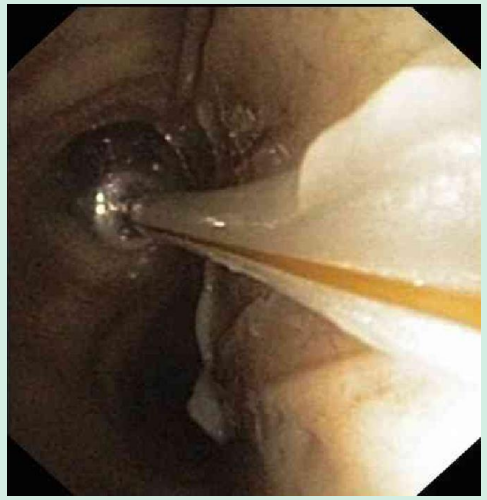


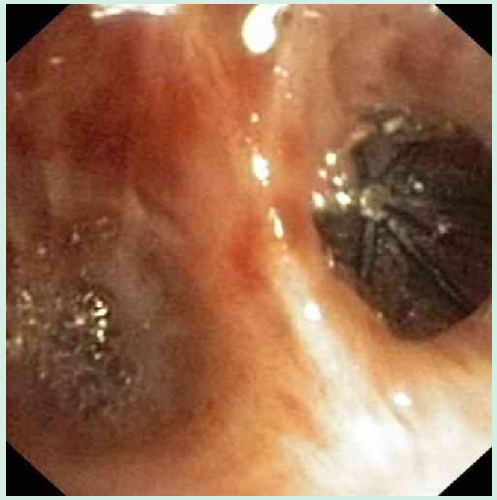
2012 – BVR (vlevo B6) zlepšení symptomů a tolerance zátěže, ale za 12M
2013 – opak.AE, PaO_2 8,82 (se 3L O_2), mMRC 4, 6MWD 180m – extrakce IBV (hlenoprodukce a AE) – PDE4i + IKS/LABA



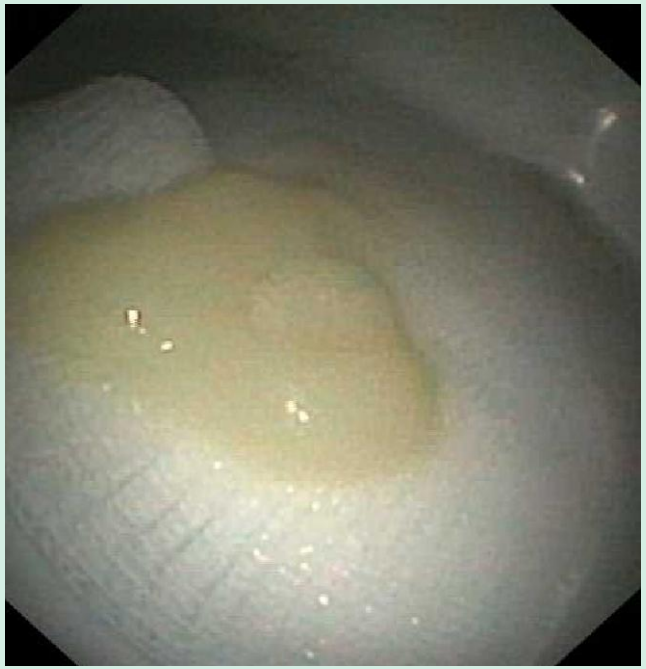


2012

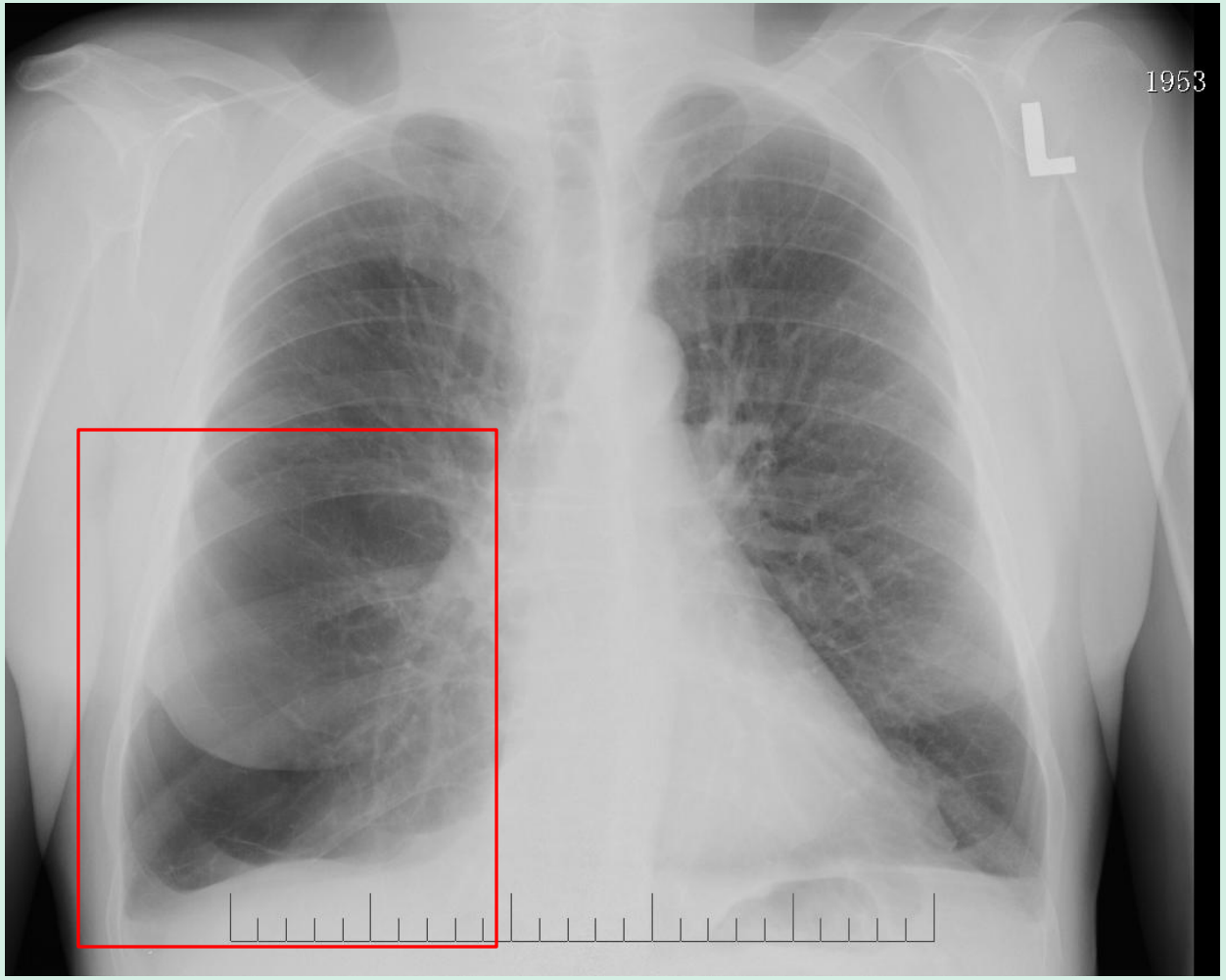


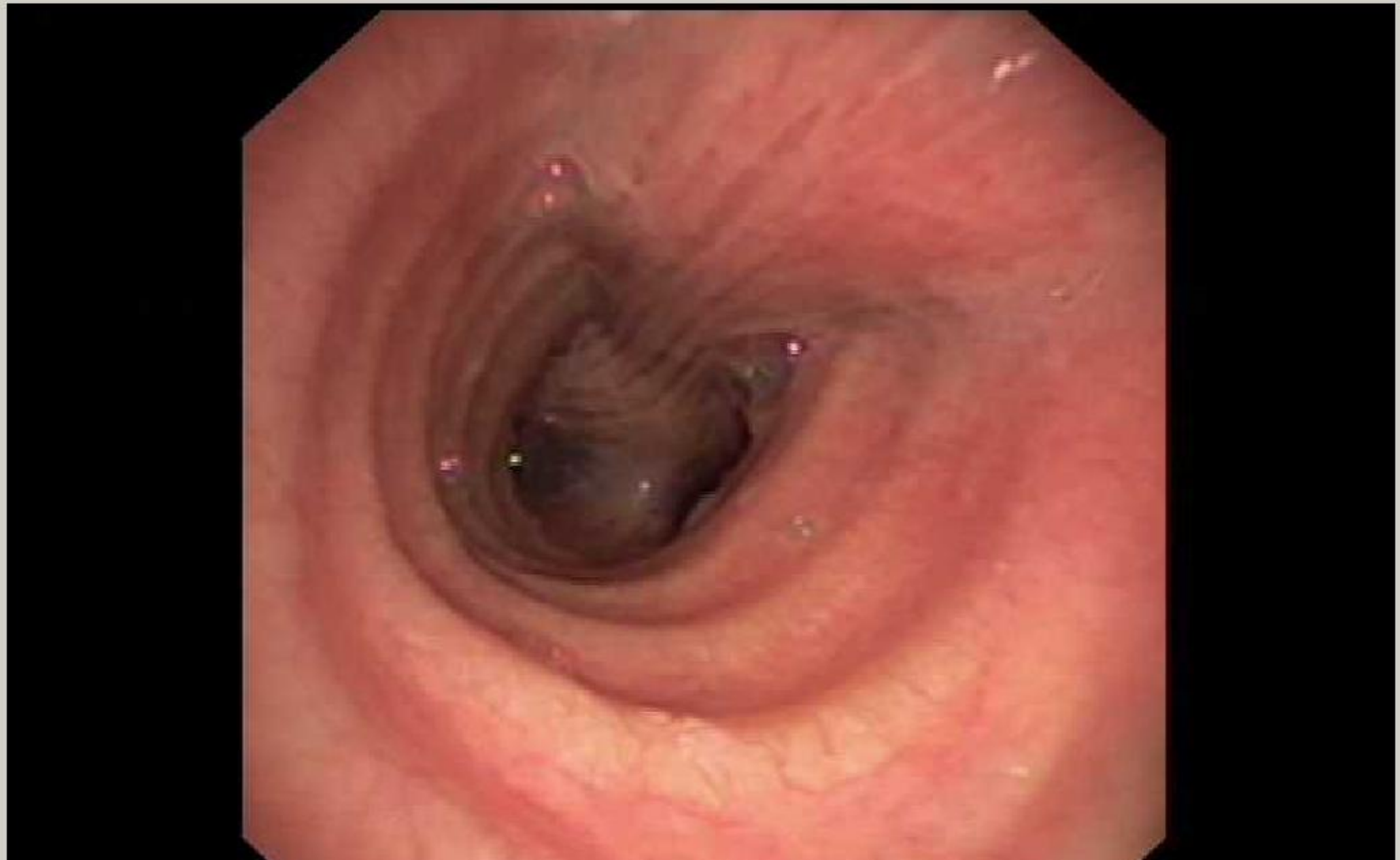


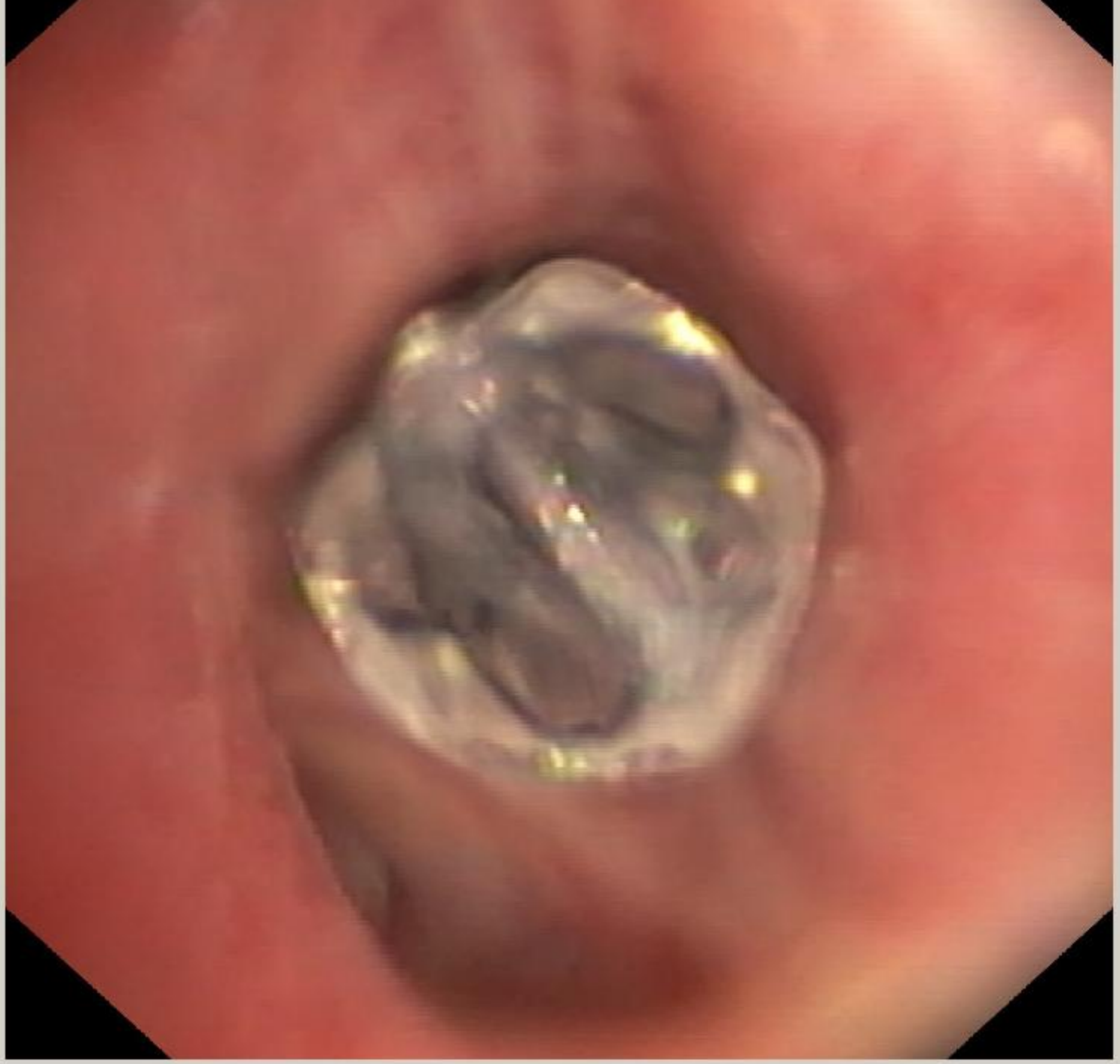
2013

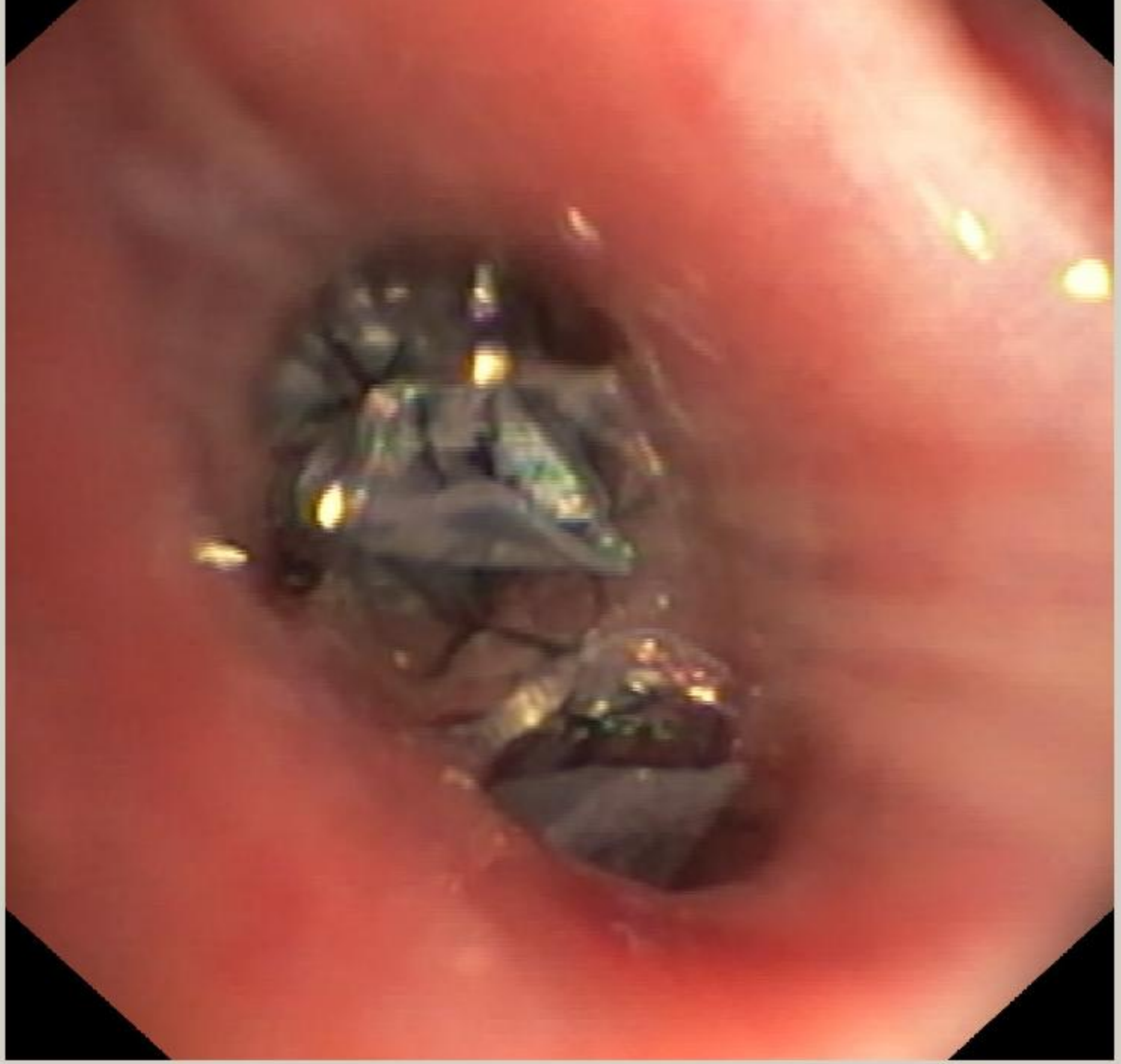


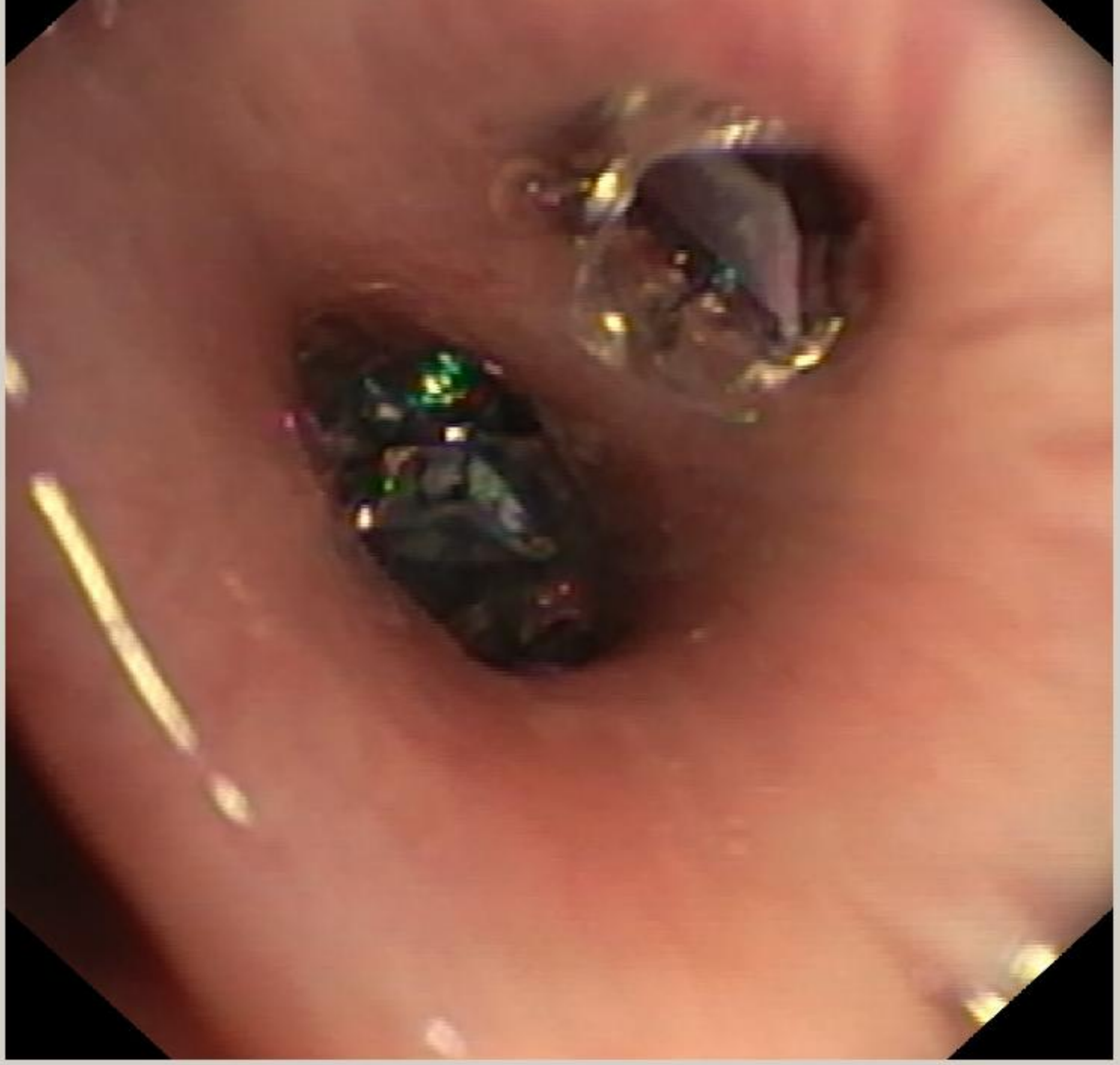
Klinický příklad II

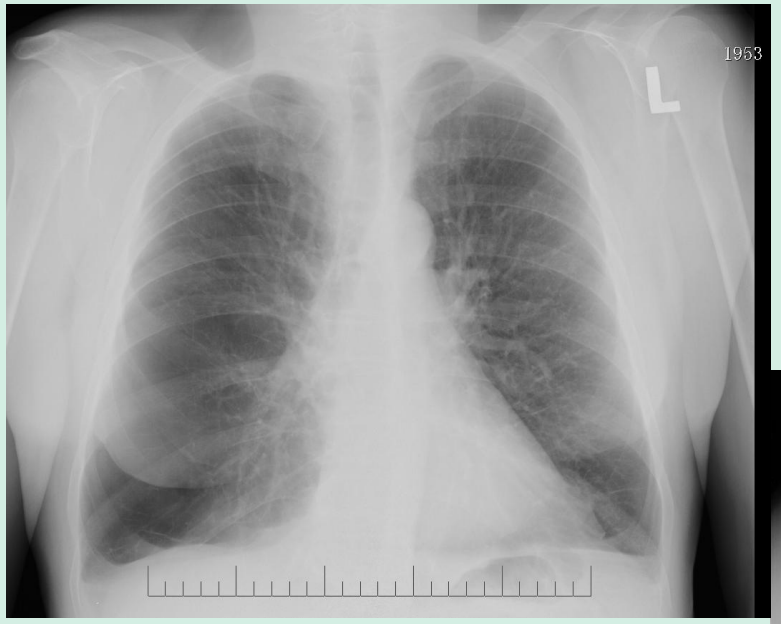


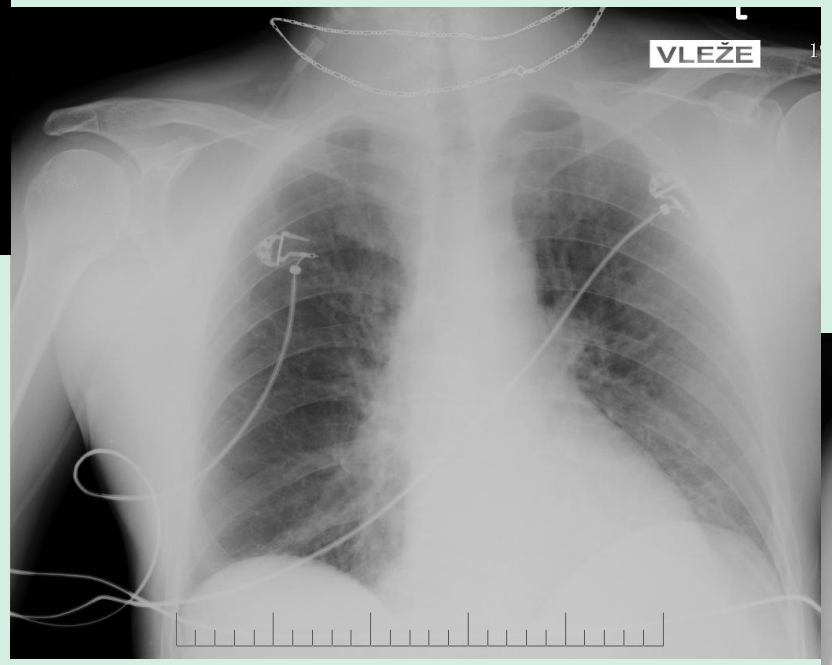


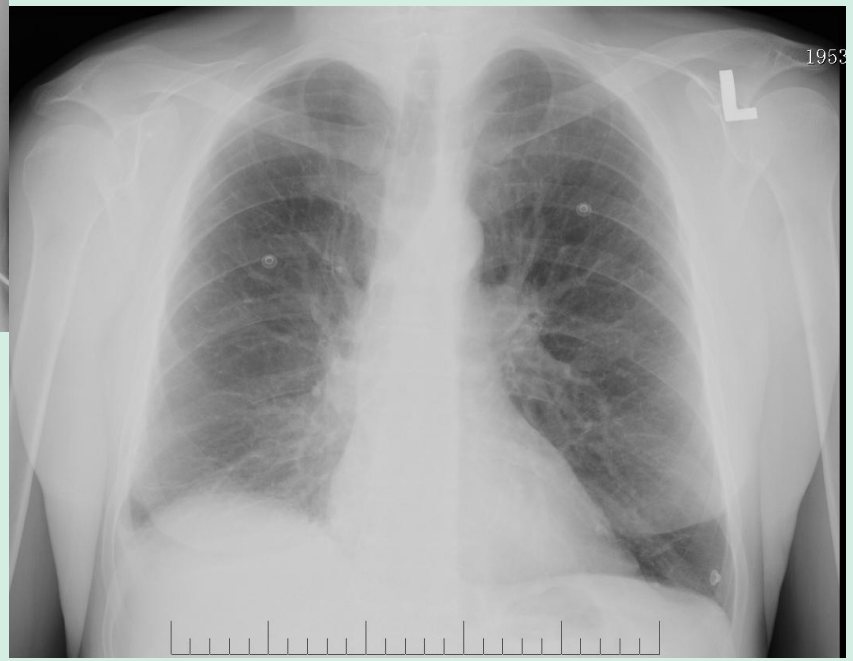







1953
L

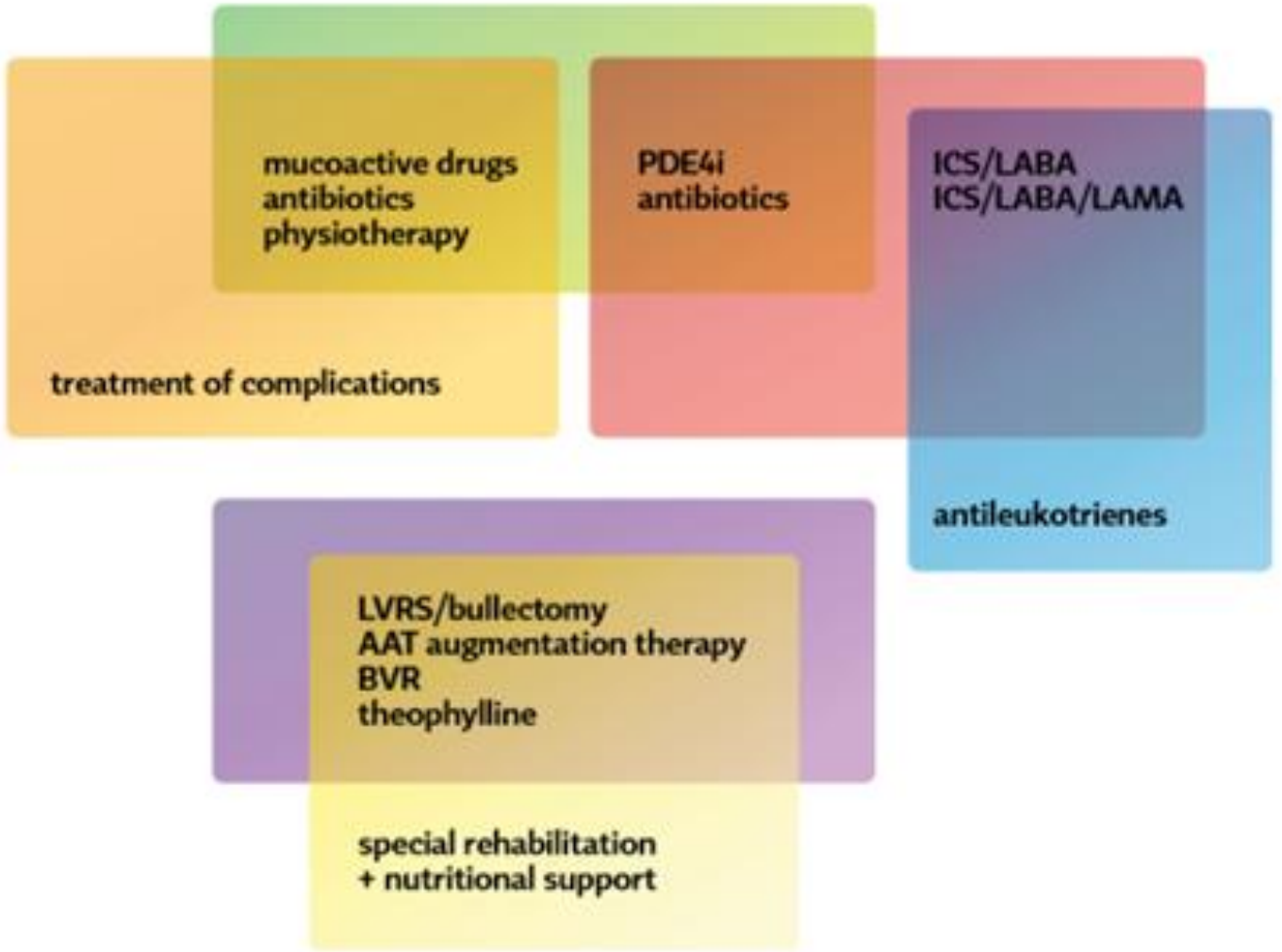

VLEŽE


1953
L

Výsledky klinického příkladu II.

- Před výkonem mMRC 3, 6MWD 330m, FEV_1 27%, RV 273%
- **Po 2M od výkonu mMRC 1, 6MWD 420m, FEV_1 52%, RV 187%**

Figure 4: Simplified diagram of phenotype-specific COPD treatment (3rd step)




NEVAŘTE NIC, DOKUD JSTE NEČETLI TUTO KNIHU!
VAŘTE JAKO ŠÉF!
ŠKOLA VAŘENÍ ZDEŇKA POHLREICHA

Validace fenotypického pohledu (studie ČR)

ClinicalTrials.gov
A service of the U.S. National Institutes of Health

Example: "Heart attack" AND "Los Angeles"
Search for studies: Search
Advanced Search | Help | Studies by Topic | Glossary

Find Studies | About Clinical Studies | Submit Studies | Resources | About This Site

Home > Find Studies > Study Record Detail

Text Size

Czech National Research Database of Chronic Obstructive Pulmonary Disease (COPD)

This study is currently recruiting participants.

Verified August 2013 by *Masaryk University*

Sponsor:
Karel Hejduk

Information provided by (Responsible Party):
Karel Hejduk, Masaryk University

ClinicalTrials.gov Identifier:
NCT01923051

First received: August 7, 2013
Last updated: August 13, 2013
Last verified: August 2013
History of Changes

Full Text View | Tabular View | No Study Results Posted | Disclaimer | How to Read a Study Record

Purpose

The chronic obstructive pulmonary disease (COPD) is the occurrence of chronic bronchitis or emphysema, a pair of commonly co-existing diseases of the lungs in which the airways narrow over time. This limits airflow to and from the lungs, causing shortness of breath (dyspnoea). In clinical practice, COPD is defined by its characteristic airflow limitation on lung function tests. In contrast to asthma, this limitation is poorly reversible and usually gets increasingly worse over time.

The COPD registry is a non-interventional multicentre observational prospective database focusing on the collection and analysis of data on real mortality and morbidity in COPD population of the Czech Republic population of COPD patients. Monitoring is done at the occasion of regular check-ups, followed by retrospective search of data in the documentation, and a record into the registry.

The aim of Czech National Research Database of Chronic Obstructive Pulmonary Disease is to establish the clinical course of severe forms of COPD, establish the cause for deterioration of clinical status of our patients and describe the progression of COPD to death.

Condition
Chronic Obstructive Airway Disease

Study Type: Observational
Study Design: Observational Model: Cohort
Time Perspective: Prospective

Official Title: Czech National Research Database of Chronic Obstructive Pulmonary Disease (COPD): Registry of the Czech Pneumological Society (CPPS) at the Czech Medical Association (CzMA)

Validace fenotypického pohledu (studie CEE)

Protocol Title:	**POPE-Study:** **Phenotypes Of COPD in Central and Eastern Europe Study**
Protocol Draft:	**1.0**
Protocol Date	**Oct 29th, 2013**
Steering Committee of the COPD PLATFORM	Arschang Valipour, AU Vladimir Koblizek, CZ Ruzena Tkacova, SK Nestor Tudoric, HR Kyrill Zykov, RU Attila Somfay, HU Adam Barczyk, PL Marc Miravittles, SP
CRO	IBA Brno, CZ Zuzana Zbozinkova,
Aims of the study	**To assess the distribution of patients with COPD in clinical practice within the CEE region according to disease severity, disease category, and phenotypes.**
Primary outcome	• To determine the proportion of patients within the GOLD 2011 strategy disease severity (Stage 1,2,3,4) and risk classification category (A,B,C,D) in an unselected group of consecutively examined patients with COPD in the CEE region.
Secondary outcomes	• To evaluate the prevalence of disease phenotypes according to predefined criteria • To evaluate the diagnostic approach to COPD in CEE countries • To assess the differences in treatment habits in CEE countries

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Inclusion Criteria	A) Age > 40 years B) Diagnosis of COPD and post BD $FEV_1/FVC < 0.7$ C) Stable disease for at least 4 weeks D) Smoking history of > 10 packyears E) Informed Consent
Exclusion Criteria	A) Post-BD FEV1/FVC > 0.7 B) Life-long non-smoker C) Patient is not willing to participate
Statistical analysis	Institute of Biostatistics and Analyses, Masaryk University, Brno, Czech Republic
Statistical plan	According to power calculation analysis and equal distribution of patients per participating country, a total of 3500 patients from the CEE region will be required for an estimated 20% prevalence of frequent disease categories with a precision of roughly ± 1.3 % in the CEE region and ± 3.6 % within each participating country. Prevalence of less frequent categories (5% prevalence) will be estimated with a precision of roughly ± 0.7 % in the CEE region and ± 2.0 % within each participating country. This sample size allows to detect statistically significant differences in the relative risk of categories between different countries

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Zdroje informací