

EDITORIAL

COPD: COMMON YET NEGLECTED

Chronic obstructive airway disease (COPD) is common in most communities of the world (1). In US it is the fourth leading cause of chronic morbidity and mortality, while it is projected that it will be the third leading cause of death worldwide by 2020 (2). With rising incidence of smoking, urbanization and lack of proper health care, it should be no surprise that we continue to see more and more cases of the disease by the years.

Despite its enormous burden, it can be argued that COPD has not received as much attention in our country, say for example, as compared with asthma. In fact most average physicians do not tend to differentiate between the two diseases and treat any breathlessness (or wheeze) as 'asthma'. While both diseases may benefit from pharmacologic agents like bronchodilators and steroids, they are mostly different in many perspectives including pathogenesis and prognosis. Assessment should include spirometry, at least initially, which is not widely available in our country. Treatment modalities, acutely, are similar to asthma in many ways but the long term management is very different.

Another point of interest is the recognized association of COPD with pulmonary tuberculosis, so common in our country. While anecdotally seen often together, it may be of interest to scientifically assess the magnitude of both the diseases in Pakistan on a large scale.

The association with smoking is beyond any hint of doubt. In Pakistan, with the rising number of tobacco users, with no effective implementation of prevention in sight, one feels that the numbers of patients would shoot to exponential degrees within a short span of time. The economic burden of the disease is enormous (3). This includes cost of treatment, hospitalization for exacerbations, and not-to-be-forgotten loss of valuable working days. Furthermore the disease in its advanced stages is as crippling and disabling as for example cancer, and yet people still take it lightly. I often show actual or pictures of advanced COPD patients to smokers in an attempt to convince them for quitting. The misery of 'not being able to do things of daily life' is unbearable to most patients who quite commonly have depression as a major disorder. This is the stage of no return, almost. Time to act is *before* it happens.

The most important aspect in management of COPD patient is undoubtedly cessation of smoking, the commonest risk factor (4, 5). Yet it should not be disputed that as a community, as well as physicians we are lacking far behind the required efforts. Lack of health education in our 'busy' clinics, absence of smoking cessation clinics in almost all major institutions, and the less-than-optimal utilization of media in this key issue are some of our own shortcomings.

Finally the under usage of rehabilitation and long term oxygen for COPD patients is one important issue. While its benefits are now increasingly proved and acknowledged, in Pakistan both lack of appreciation and of availability of rehabilitation for such patients is to be noted. Oxygen for domestic, long term use is both poorly available with no controls over standards, and costly

In summary one feels that COPD is on one hand common in our community and on the other not given its due importance by us, the physicians. There are indeed clusters of efforts but far short of what is required. We as chest physicians' society should take up the challenge more seriously; wider dissemination of guidelines, allocation of more time to COPD in our CME, developing expertise in pulmonary function tests, smoking cessation and rehabilitation and to say the least increasing advocacy in anti smoking campaign are some of the duties we should actively accept. *Let us be more vibrant where most required!*

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