

PostScript

LETTERS TO THE EDITOR

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Usefulness of GOLD classification of COPD severity

In 2001 the US National Heart, Lung and Blood Institute (NHLBI) and the World Health Organization announced guidelines for the diagnosis, management, and treatment of COPD (Global Initiative for Chronic Obstructive Lung Disease, GOLD).¹ One key aspect of these guidelines is that COPD is classified by severity into five stages which constitute the basis of treatment recommendations. However, to date there has been little evidence for the usefulness of these severity stages.

We retrospectively reviewed 1000 patients with COPD diagnosed clinically in 2001; 500 patients originated from a pulmonary rehabilitation hospital. Patients' symptoms (based on a standardised interview), findings of a standardised lung examination, lung function

data, and chest radiographic findings are routinely documented in a database. The inclusion criteria were symptoms of COPD (chronic cough with chronic sputum production for more than 2 years) and radiographic findings of COPD (hyperinflation, diaphragmatic flattening). Patients with a history of asthma (variability of spirometric parameters, improvement in forced expiratory volume in 1 second (FEV₁) of >20% after inhalation of β_2 agonists, symptoms predominantly at night, seasonal allergies, allergic rhinitis, or eczema) were excluded from the study, as were those in whom FEV₁ and forced vital capacity (FVC) differed by more than 5% according to the American Thoracic Society (ATS) guidelines² and patients with an abnormal chest radiograph or chronic cough caused by a disease other than COPD.

FEV₁ and FEV₁/FVC were determined three times. The predicted values for FEV₁ were taken from the European Respiratory Society (ERS) guidelines.³ The individual values of FEV₁ and FEV₁/FVC for all patients are shown in fig 1. Almost 14% of patients clinically diagnosed as having COPD could not be classified because they had an FEV₁/FVC ratio of >70%, despite having a reduced FEV₁ (<80% predicted). This combination is not represented in the GOLD classification. Less than 5% of all patients were classified as GOLD stage I.

The finding that the GOLD classification missed an important subgroup of patients with mild COPD challenges any proposed advantage of this classification scheme over existing guidelines from the ATS⁴ and ERS.⁵ Only six patients not classified as having COPD by GOLD were missed using the ATS criteria (stage I: FEV₁ \geq 50%) and ERS criteria (mild: FEV₁ \leq 70% and FEV₁/FVC >88% for men and >89% for women). Obviously, any arbitrary classification of a continuous variable such as FEV₁ and FEV₁/FVC results in a borderline group of patients. The GOLD classification, however, provides no guidance

as to the further diagnosis of the unclassified subgroup (fig 1). Our results also show that stage I disease (FEV₁/FVC <70% and FEV₁ >80% predicted) was very rare, constituting only 4-5% of the patients. This indicates that the distribution of the stages, especially stage I, is inhomogeneous.

Despite its retrospective design, this study was strengthened by the fact that lung function data, chest radiographic findings, and the results of a standard clinical examination were available for all patients. It therefore offers the chance to investigate the clinical impact of the GOLD classification, especially in patients with mild COPD.

Our study therefore suggests that GOLD criteria miss an important subgroup of patients with clinically diagnosed COPD, which reduces its usefulness as a clinical tool.

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Sahaja yoga in asthma

Since the publication of our paper on Sahaja yoga in the management of moderate to severe asthma¹ we have received a large number of enquiries. One issue that has been raised about the technique used in the study warrants clarification and further acknowledgement.

The Sahaja yoga meditation technique used in the study was *not* developed by the authors. The technique was taught to subjects in the intervention group by experienced Sahaja yoga practitioners free of charge. The technique itself was developed by yoga expert H H Shri Mataji Nirmala Devi and she permitted the investigators to conduct the study on the following reasonable conditions: (1) that no part of the technique be misrepresented, misappropriated or commercialised by the investigators; (2) that the founder and practitioners of the process be appropriately

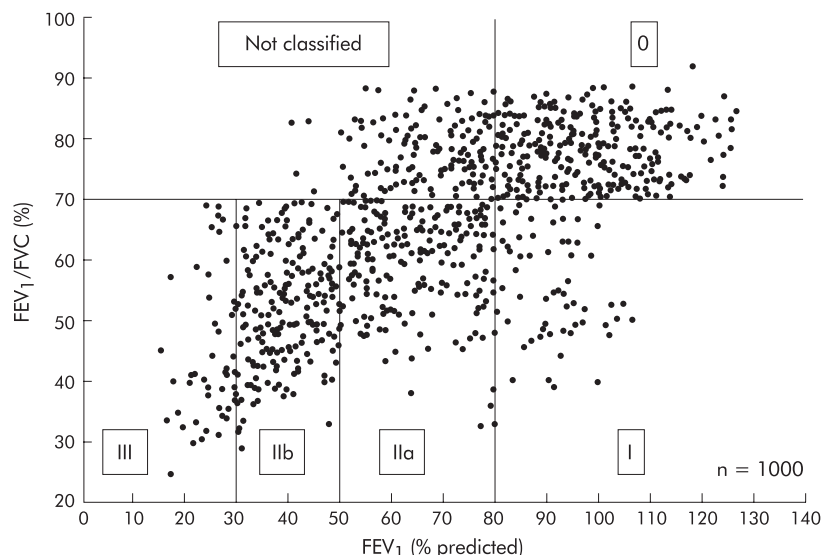


Figure 1 Plot of % predicted forced expiratory volume in 1 second (FEV₁) against the ratio of FEV₁ to forced vital capacity (FVC) (%) of the total population (n=1000).