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Memorandum

To: UMHS Physicians, Nurse Practitioners and Physicians Assistants

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Subject: **UMHS Clinical Care Guideline: Care of the Hospitalized Patient with Acute Exacerbation of COPD**

What's New!

These new guidelines have been developed to assure consistent care delivery for patients with AECOPD across the inpatient services. Given the vast spectrum of patient presentations and the breadth of treatment options, management of AECOPD patients is inherently complex. Patients presenting with AECOPD may receive inconsistent care.

Key Aspects of Care

- The diagnosis of AECOPD is usually made by a clinical assessment that combines historical features, identification of triggers of worsening disease, physical exam findings and ruling out other conditions with similar clinical presentations.
- Testing should include a CBC, a CXR, influenza nasal swab (seasonal), and an ECG in most patients. Additional testing is indicated when an alternate condition is suspected.
- Assessment of Severity and Intensity of Care. The early evaluation for patients with COPD should identify patients that will require hospitalization, ventilatory support, or ICU admission.
- Inhaled bronchodilators
  - Patients hospitalized with AECOPD should be treated with inhaled albuterol and/or ipratropium, with dose and frequency titrated to effect.
  - Metered-dose inhalers (MDI's), with spacer devices, are the preferred delivery method for short-acting bronchodilators, unless the patient's condition or preference warrants the use of a nebulizer.
- Corticosteroids
  - Most patients who are hospitalized with an exacerbation of COPD should be treated with systemic corticosteroids, unless side-effects are limiting.
  - A dose of prednisone, 40 mg orally daily, for a 5-day course, is appropriate for most patients, and a dose taper is unnecessary.
- Antibiotics
  - Most patients who are hospitalized with AECOPD should be treated with antibiotics.
- A 5-day duration of antibiotics is likely adequate for inpatients that demonstrate rapid improvement. Longer courses (7-10 days) may be considered for patients with severe illness or those who are slow to respond to treatment.
- Supportive care
  - Acute oxygen therapy. Oxygen should be provided to treat hypoxemia to a pulse-ox target of 88-92%.
  - Non-invasive positive pressure ventilatory support (NIPPV).
    - NIPPV in the form of BiPAP (or CPAP) should be initiated in patients with AECOPD who have persistent or worsening respiratory distress, hypoxemia, or respiratory acidosis despite medical therapy.
    - NIPPV should be initiated early in AECOPD.
    - Predictors for success and contraindications should be highlighted when considering the use of NIPPV.
    - Patients who are started on NIPPV should be monitored closely, and the decision whether or not to intubate should be made within 2 hours of starting NIPPV.
- Preventative care in the hospital should include smoking cessation interventions, appropriate vaccinations, and venous thromboembolism prevention.
- A comprehensive approach to discharge is recommended.

All UMHS Inpatient Clinical Care Guidelines can be found at: http://www.uofmhealth.org/provider/clinical-care-guidelines