

Diagnose by post-bronchodilator spirometry ($FEV_1/FVC < 0.7$) — then classify by symptom burden and exacerbation history (GOLD ABE) to guide initial therapy. Smoking cessation remains the single most effective intervention available — see the Smoking Cessation sheet (EN-09).

Diagnostic pathway

From clinical suspicion to escalation.

- 1 Suspect: smoking history, dyspnoea, cough, sputum, age > 40
- 2 Confirm: post-BD spirometry — $FEV_1/FVC < 0.7$
- 3 Assess: CAT/mMRC + exacerbation history → Group A/B/E
- 4 Initiate: smoking cessation + inhaler per group + vaccines
- 5 Optimise/refer: pulmonary rehab, LTOT if indicated, specialist if severe

GOLD ABE classification

Symptom burden + exacerbation risk → initial bronchodilator choice.

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| A | Low symptoms (CAT<10, mMRC 0–1), ≤1 exacerbation/yr, no hospitalisation — single bronchodilator (LAMA or LABA) |
| B | Higher symptoms (CAT≥10 or mMRC≥2), ≤1 exacerbation/yr, no hospitalisation — LABA+LAMA combination |
| E | ≥2 exacerbations/yr or ≥1 hospitalisation — LABA+LAMA; consider adding ICS if blood eosinophils ≥300 cells/ μ L |

INHALER CHOICE & FEV1 STAGING

Device class selection (LAMA/LABA/ICS combinations, brands) — see the **RS-03 Inhaler Decision Guide**. GOLD 1–4 FEV1 staging informs prognosis but not initial Rx, which follows ABE group. Reversibility testing is not routinely needed once $FEV_1/FVC < 0.7$ is confirmed.

ACUTE EXACERBATION

Anthonisen cardinal symptoms: increased dyspnoea, increased sputum volume, increased sputum purulence. Purulent sputum is the key trigger for antibiotics; the more cardinal symptoms present, the stronger the case. Give SABA+SAMA (spacer/nebuliser) and a short oral corticosteroid course; confirm current antibiotic choice and duration at eTG/COPD-X, as stewardship guidance evolves.

NON-PHARMACOLOGICAL CARE

- **Smoking cessation** — slows FEV1 decline; the single most important intervention.
- **Pulmonary rehabilitation** — a structured ~6–8 week program (Lung Foundation Australia); refer all symptomatic patients.
- **Vaccination** — annual influenza, pneumococcal, COVID-19, and RSV in eligible groups.
- **LTOT** — consider if $PaO_2 \leq 55$ mmHg or $SpO_2 \leq 88\%$ on room air at rest in a stable state; refer respiratory.

ANNUAL REVIEW & CARE PLANS

Spirometry annually to track FEV1 decline. Check inhaler technique at every visit and maintain a written action plan. Check eosinophils before adding ICS. A chronic-condition GP management plan applies (the GPCCMP replaced the old GPMP/TCA items, incl. former item 721, from 1 Jul 2025) — confirm the current item number and rebate at mbsonline.gov.au.

■ SAFETY

- Confirm with post-BD spirometry before labelling COPD — asthma overlap is common
- Continue maintenance inhalers through an exacerbation; don't stop them
- Poor inhaler technique can mimic treatment failure — check at every visit
- Don't start unsupervised home oxygen outside LTOT criteria — risk in CO2 retainers

■ RED FLAGS / REFER

- Diagnostic uncertainty, age < 40, or suspected alpha-1 antitrypsin deficiency
- ≥2 exacerbations in 12 months despite optimised therapy
- Persistent symptoms with $FEV_1 < 50\%$ predicted despite optimised therapy
- Consideration of LTOT, or surgical/transplant assessment