Asthma COPD Overlap Syndrome (ACOS)

NHS Calderdale CCG, NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Wakefield CCG with Mid Yorkshire Hospitals NHS Trust and Calderdale and Huddersfield Hospital Foundation Trust, LOCALA CIC.

- A significant proportion of patients who present with symptoms of a chronic airways disease have features of both asthma and COPD
- Patients with features of both asthma and COPD experience frequent exacerbations, have poor quality of life, a more rapid decline in lung function and higher mortality than asthma or COPD alone
- Concurrent clinician diagnosed asthma and COPD has been reported in between 15% and 20% of patients
- Distinguishing asthma from COPD can be problematic, particularly in smokers and older adults
- ACOS is characterised by persistent airflow limitation with several features usually associated with asthma and several features usually associated with COPD
- ACOS is therefore identified by the features that it shares with both asthma and COPD
- **ACOS code on SytsmOne Xac33 EMIS H3B SNOMED code is 10692761000119107**

Feature if present suggests:	**Asthma**	**COPD**
Age of onset	• Under 20 years old	• Over 35 years old
Pattern of symptoms	• Variation over minutes, hours or days • Worse during the night or early morning • Triggered by exercise, emotions including laughter, dust or exposure to allergens	• Persistent despite treatment • Good and bad days but always daily symptoms and exertional dyspnoea • Chronic cough and sputum preceded onset of dyspnoea, unrelated triggers
Lung function	• Record or variable airflow limitation (Spirometry, Peak Flow)	• Record of persistent airflow limitation (FEV_1/FVC < 0.7 post Bronchodilation)
Lung function	• Normal between symptoms	• Abnormal between symptoms
Past history and family history	• Previous clinician diagnosed asthma • Family History of Asthma or other allergic conditions (allergic rhinitis, eczema)	• Previous clinician diagnosis of COPD, chronic bronchitis or emphysema • Heavy exposure to risk factor, tobacco smoke, biomass fuels, occupation
Time course	• No worsening of symptoms over time • Varied symptoms either seasonally or from year to year • May improve spontaneously or have an immediate response to bronchodilators or inhaled corticosteroid over weeks	• Symptoms slowly worsening over time (progressive course over years) • Rapid acting bronchodilator treatment provides only limited relief
Chest Xray	• Normal	• Severe hyperinflation

These features distinguish between asthma and COPD. Several positive features (3 or more) for either asthma or COPD suggest that diagnosis. If there are similar numbers for both asthma and COPD, consider a diagnosis of ACOS

Treatment should be selected to ensure that:

- Patients with features of asthma receive adequate controller therapy including inhaled corticosteroids, but not long-acting bronchodilators alone (as monotherapy), and
- Patients with COPD receive appropriate symptomatic treatment with bronchodilators or combination therapy, but not inhaled corticosteroids alone (as monotherapy)
- **Initial recognition and treatment of ACOS may be made in primary care, referral for confirmatory investigations is encouraged, as outcomes for ACOS are often worse than for asthma or COPD alone**
- **E-consultation should be utilised if available**

References

Chronic obstructive pulmonary disease in over 16s: diagnosis and management July 2019 **https://www.nice.org.uk/guidance/NG115**

Global Initiative for Chronic Obstructive Lung Disease. 2019 Report. https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-v1.5-FINAL-04Nov2018_WMS.pdf

NICE COPD Quality Standards https://www.nice.org.uk/guidance/qs10/resources/chronic-obstructive-pulmonary-disease-in-adults-pdf-2098478592709

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