LETTER TO THE EDITORS Earlier detection of COPD***Rupert Jones^a**

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Dear Sirs,

Conventional advice is so dull and we all love the maverick. In their refreshing and plausible editorial in the most recent issue of the *PCRJ*, Enright and White challenge the conventional wisdom on early detection of COPD by stating that early detection of COPD is a waste of resources.¹ The advice they offer is attractive, but it should not be trusted and here is why.

If we do not detect early symptomatic disease, we detect it late – i.e. when the lung damage is irreversible and will progress. The decline in lung function is much faster in GOLD stages I to II than it is for stages III or IV.² There is no evidence that late smoking cessation reduces decline in lung function. If symptomatic individuals with COPD are not diagnosed early, they are denied proper education on the management of symptoms and preservation of lung function. Furthermore, they have no access to pulmonary rehabilitation or drugs which can improve symptoms and reduce exacerbations.

Opportunistic case finding of symptomatic disease does not involve additional resources of screening; certainly in the UK, this is part of the core services that primary care should provide and is remunerated to do so. The authors state that in many countries clinicians fail to manage patients with diagnosed COPD effectively, but this does not mean that earlier diagnosis is wrong.

The authors correctly state that the progression of early disease is unclear, but patients with symptomatic GOLD stage I are more likely to progress³ – which is why only symptomatic people should be diagnosed. All major guidelines recommend early diagnosis of symptomatic disease – the most recent being the UK NICE guidelines,⁴ which examined the subject very thoroughly and state: “Spirometry should be performed in patients who are over 35, current or ex-smokers, and have a chronic cough. Spirometry should be considered in patients with chronic bronchitis. A significant proportion of these will go on to develop airflow limitation.”

Following the nihilistic advice in Enright and White’s editorial¹ will condemn people to preventable, intractable lung disease.

Conflict of interest

RJ has been paid to take part in educational activities related to COPD for Altana, AstraZeneca, Boehringer Ingelheim (BI), GlaxoSmithKline, Novartis, Nutricia, Pfizer, TEVA, Tejin and Chiesi in the last 3 years. He is consultant to Global emPOWER and COPDexchange educational programmes supported by Pfizer and BI

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