Patients with COPD often learn to cope with or “accommodate” their symptoms, which presents a challenge for nurses in terms of assessment and treatment.

**Symptom “accommodation” in patients with COPD**

**In this article...**
- How patients “accommodate” symptoms of COPD
- How to assess disease severity
- How to provide good support and achieve positive outcomes

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**Abstract** Davies N (2012) Symptom “accommodation” in patients with COPD. Nursing Times; 108: 34/35, 17-20. Patients with COPD often learn to “accommodate” their symptoms, which makes it difficult for health professionals to assess the impact of the condition on their daily lives. This article explores the concept of accommodating COPD symptoms and gives advice to encourage optimal treatment.

**Disease severity and quality of life can be poorly correlated.** While some patients classed as having severe chronic obstructive pulmonary disease (COPD) may report having good quality of life, they may have learned to “accommodate” their symptoms and therefore do not feel the disease has made a significant impact on their everyday lives. On the other hand, those defined as having mild COPD may report having poor quality of life and feel the condition has taken over their lives.

Although spirometry is an important tool in managing COPD, the measurement of FEV1 should not be used in isolation, as it is not always linked to patients’ reported quality of life (Jones, 2001). Regular reassessment is a vital part of managing this disease; this article explores the impact that accommodating symptoms can have on patients’ condition and offers practical advice to encourage optimal treatment with the aim of improving quality of life and reducing hospital admissions.

**Accommodating symptoms**
The main symptoms of COPD include progressive breathlessness on exertion, chronic cough, regular sputum production, frequent episodes of “winter bronchitis” or “chest infections”, and wheeze. Many people have not heard of COPD and those who have the condition in the mild or early stage often dismiss symptoms as an inevitable sign of being unfit, or do not seek help for fear of being stigmatised (Healthcare Commission, 2006). By the time patients seek help, it is often because their breathlessness has become intolerable and has a major impact on their quality of life.

Early on in the disease pathway, breathlessness may only occur during strenuous exercise. As the disease progresses, exertional breathlessness can become so severe it becomes disabling, leading to further inactivity. Patients’ consequent inability to perform the simplest of daily tasks without exhaustion can lead to social isolation and depression (British Lung Foundation, 2007). However, avoiding exercise leads to physical deconditioning, which means that even simple household chores can precipitate breathlessness. As a result, patients choose to do less which, in turn, means they are able to do less. Eventually, even activities of daily living (such as washing or dressing) can cause severe symptoms, limiting what people can do in their everyday lives. This leads to their becoming more reliant on partners and families (Fletcher et al, 2011).

As the rate of COPD decline is slow, patients often accept and learn to accommodate their symptoms (for example, by walking more slowly and avoiding activities they know worsen their level of breathlessness); consequently, they accept their symptoms as a way of life. As a result, patients are often diagnosed much later in the disease progression as having “moderate” or “severe” disease.

The problem of people accommodating symptoms is not solely restricted to the diagnosis phase, but also presents a challenge for nurses in the continued management of those with COPD and in ensuring their treatment is optimised. The case study in Box 1 shows how practice nurse support helped a patient to quit smoking and pulmonary rehabilitation improved her COPD.

**Key points**

1. Patients’ coping with the limitations of COPD can make identifying the optimal time to intervene difficult.
2. Practitioners need to be proactive in encouraging patients to discuss symptoms, as early identification can slow the decline of lung function.
3. Optimal COPD management can improve quality of life, reduce likelihood of exacerbations and keep patients out of hospital.
4. Practitioners can use assessment tools in consultation to assess a patient’s breathlessness and disease severity.
5. Encouraging patients to stop smoking is vital in managing COPD.

**Tools for assessment**
During consultations it can be difficult to assess whether a patient’s condition has deteriorated; simple questions such as “how do you feel?” or “are you feeling more breathless?” may be difficult for patients to put into context and answer due to the slow progressive decline of the disease. Severity of disease and its impact can be measured using multidimensional tools that not only measure lung function, but also other parameters such as breathlessness. Two examples of such tools that are useful in primary care are given below.

Inhaler technique should be checked.
Medical Research Council dyspnoea scale
The Medical Research Council dyspnoea scale is commonly used to measure breathlessness (Fletcher et al, 1959) (Table 1). It can provide a simple way to quantify the impact of breathlessness for patients with COPD as well as information on how much or how little they are able to do. Patients rate their level of breathlessness using a five-point scale, choosing the grade that represents their symptoms most closely; the higher the grade, the greater the limitations imposed by their disease. However, the use of the scale can be limited, due to the restricted choice between the grades.

COPD Assessment Test
The COPD Assessment Test (CAT) is a simple tool that patients complete to measure their health status (www.catestonline.co.uk). It contains eight items, which cover cough, phlegm, chest tightness, exertion, level of activity at home, confidence, sleep and level of reported energy, and can provide a more holistic assessment of the impact of COPD on patients. Each scenario is marked 0-5, with the best having a low rating and the worst having a high rating. This provides a total score of 0-40; patients with a CAT score of >30 may need input from a respiratory specialist to optimise treatment and improve health outcomes (Jones et al, 2009).

Each individual statement can also provide information about patients that may need to be addressed further. The statements in the confidence scenario, “I am confident leaving my home despite my lung condition” or “I am not at all confident leaving my home because of my lung condition” could be used as an opportunity to explore any potential concerns, and referral to a member of the multidisciplinary team, such as a physiotherapist, psychologist or occupational therapist, could be made.

Further support
Smoking cessation
Encouraging patients to stop smoking is one of the most important aspects of managing COPD (National Institute for Health and Clinical Excellence, 2010). Although lost lung function cannot be restored, those who do give up smoking are likely to experience lung function deterioration at a slower rate (Fletcher et al, 1976). In addition, continuing to smoke can complicate further treatment such as oxygen therapy due to the potential dangers associated with smoking and oxygen use (Lacasse et al, 2006).

Oxygen therapy
The British Thoracic Society and the Primary Care Respiratory Society clearly state oxygen should be used to treat hypoxia and not breathlessness (IMPRESS, 2010); health professionals need to be confident in reinforcing this message with their patients. Patients need to be properly assessed for long-term oxygen therapy, it must be appropriately prescribed and patients should be followed up.

Pulmonary rehabilitation
Pulmonary rehabilitation is defined as a multidisciplinary programme of care for patients with chronic respiratory impairment; it is individually tailored and designed to optimise the individual’s physical and social performance (NICE, 2010). This intervention can produce significant improvements in exercise tolerance, activities of daily living and health status, and can subsequently reduce the number of days spent in hospital by patients admitted with an acute exacerbation of COPD (NICE, 2010). Pulmonary rehabilitation should be offered to all appropriate patients who consider themselves to be functionally disabled by COPD (MRC dyspnoea scale score of ≥3), including those who have recently been admitted to hospital for an exacerbation (NICE, 2010).
Inhaled bronchodilators

Treatment focuses on symptom control and reducing the frequency and severity of exacerbations. This is vital for managing exacerbations, breathlessness and resulting exercise limitation as these are the most distressing symptoms for many patients.

Despite the wealth of inhaled therapy available, many patients are on suboptimal treatment. NICE (2010) guidance contains an algorithm on using inhaled therapies that provides a guide to optimising treatment according to disease severity, especially in patients with persistent symptoms. However, as with all medication, its effectiveness needs to be assessed along with checking inhaler technique and concordance, not only to prevent waste and reduce costs, but also to allow patients to report whether the therapy has helped to relieve symptoms.

Managing exacerbations

Exacerbations of COPD are common and have serious implications. They are distressing and disruptive for patients, often under-reported and account for a significant proportion of the total NHS cost of caring for those with COPD (Healthcare Commission, 2006). Acute exacerbations of COPD are the second most common cause of emergency admissions and make up a total of one million hospital bed days each year in the UK (Department of Health, 2005).

Patients at risk of an exacerbation should be encouraged to be vigilant for symptoms and respond quickly by:

- Adjusting their bronchodilator therapy by increasing the frequency of short-acting bronchodilator as prescribed;
- Starting oral corticosteroids if their increased breathlessness interferes with activities of daily living (unless contraindicated);
- Starting oral antibiotics if sputum is purulent (NICE, 2010).

As with all medication, possible contraindications and further differential diagnoses need to be considered (DH, 2011). Patients should be assessed at the end of each exacerbation and referred for specialist advice if there is little or no improvement in symptoms.

**TABLE 1. MEDICAL RESEARCH COUNCIL DYSPNOEA SCALE**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Degree of breathlessness related to activities</th>
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<tbody>
<tr>
<td>1</td>
<td>Not troubled by breathlessness except on strenuous exercise</td>
</tr>
<tr>
<td>2</td>
<td>Short of breath when hurrying or walking up a slight hill</td>
</tr>
<tr>
<td>3</td>
<td>Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace</td>
</tr>
<tr>
<td>4</td>
<td>Stops for breath after walking about 100m or after a few minutes on level ground</td>
</tr>
<tr>
<td>5</td>
<td>Too breathless to leave the house, or breathless when dressing or undressing</td>
</tr>
</tbody>
</table>

*Source: Fletcher et al (1959)*

**Conclusion**

When treatment is suboptimal, it can lead to exacerbations and hospital admission, which can result in further deterioration (NICE, 2010). Nurses can be proactive in regularly re-evaluating their patients to assess whether they are still breathless or receiving suboptimal treatment by using tools in their consultations.

**References**


Fletcher M et al (2011) COPD Uncovered: The New Workplace Epidemic. tinyurl.com/Fletcher-COPD


The case study is fictitious.