4th INTERNATIONAL WORKSHOP ON LUNG HEALTH
asthma and COPD: new paradigms in preventing exacerbations in respiratory diseases

BUDAPEST 19–21 January 2017

Scientific Survey made possible thanks to the kind support of Novartis
Total participants 126

Completed survey 92
Not completed survey 34

Survey completed 73%
Survey not completed 27%

The following data are related only to COMPLETED surveys.
Participant by speciality

- a. Specialist in Pneumogy / Respiratory Medicine: 83%
- b. Specialist in Internal Medicine: 2%
- c. Specialist in Immunology: 3%
- d. GP: 3%
- e. Other (please specify): 9%
1. OF THE OPTIONS BELOW, WHAT IS YOUR DEFINITION OF EXACERBATION OF COPD?

- a. An acute worsening of respiratory symptoms that results in additional therapy (13%)
- b. An event in the natural course of the disease characterized by a worsening of the patient’s baseline dyspnoea, cough and /or sputum beyond day-to-day variability sufficient to warrant a change in management (78%)
- c. An event in the natural course of the disease that results in antibiotic and/or steroid treatment or hospitalization (7%)
- d. When the patient reports worsening of respiratory symptoms (2%)
2. IN YOUR VIEW BLOOD EOSINOPHILS PREDICT COPD EXACERBATIONS?

- a. No 45%
- b. Yes for any blood level 4%
- c. Yes if >300 cells/ul 49%
- d. Yes if <300 cells/ul 2%
3. IN YOUR VIEW IS FREQUENT EXCERBATOR A “PHENOTYPE” THAT SHOULD GUIDE THE MANAGEMENT OF COPD?

- a. Frequent exacerbator is not a stable “PHENOTYPE” 35%
- b. Frequent exacerbator is one of the easiest “PHENOTYPE” to identify and manage 30%
- c. The published data on frequent exacerbator “PHENOTYPE” are not consistent 33%
- d. No 2%
4. IN YOUR CLINICAL PRACTICE, DO YOU USE BIOMARKERS TO GUIDE YOUR MANAGEMENT OF COPD EXACERBATIONS?

- a. No 24%
- b. Yes but only in hospitalised patients 39%
- c. Yes in all the patients 19%
- d. Only C-Reactive protein for antibiotic use 18%
5. In your view what is, of the options reported below, the best intervention for preventing exacerbations of...
6. OF THE OPTIONS BELOW, YOUR DEFINITION OF SEVERE ASTHMA IS:

- **a.** Asthma that requires treatment with high dose inhaled steroids plus a second controller and/or systemic steroids to prevent it from becoming "uncontrolled" or that remains "uncontrolled" despite this therapy (61%)

- **b.** Uncontrolled asthma that is difficult to treat (2%)

- **c.** Asthma with bronchial mucosal eosinophilia, increased numbers of airway lymphocytes, mast cells and macrophages, together with increased thickness of the lamina reticularis (2%)

- **d.** Asthma that leads to permanent uncontrolled symptoms, recurrent exacerbations with the potential need for hospitalization and/or the risk of near-fatal/fatal episodes, chronic airflow impairment with an accelerated decline in lung function (35%)
7. HOW MANY PATIENTS WITH SEVERE ALLERGIC ASTHMA DO YOU SEE IN A MONTH?

- a. 0-5: 53%
- b. 6-10: 31%
- c. 11-20: 7%
- d. >20: 9%
8. IN YOUR VIEW OMALIZUMAB SHOULD BE PRESCRIBED TO:

a. Patients with moderate-high level of IgE and severe asthma 
   - 35%

b. Patients with severe allergic asthma, moderate-high level of IgE 
   - 59%

c. Patients with high level of sputum eosinophils and severe asthma 
   - 2%

d. Patients with high level of sputum eosinophils and uncontrolled asthma 
   - 4%
9. IN YOUR VIEW ANTI-IL5 DRUGS SHOULD BE USED IN:

- **a. Patients with mild-moderate asthma with blood eosinophils level >300 cells/ul**: 79%
- **b. Patients with severe asthma with blood eosinophils level >300 cells/ul**: 3%
- **c. Any asthmatic patient with blood eosinophils level >300 cells/ul**: 11%
- **d. Patients with severe allergic asthma**: 3%
THANK YOU