

A New Chimaera: Asthma-COPD Overlap in Argentina

Una nueva quimera: la superposición entre asma y EPOC en Argentina

Videla Alejandro 

These absurd conjectures prove that people were already growing quite tired of the Chimaera.
It was better to translate it into something else than to picture it.

Jorge Luis Borges

El libro de los seres imaginarios (Book of Imaginary Beings), 1967

On the occasion of the death of Dr. Alejandro Raimondi, Dr. Daniel Colodenco recalled that “He had the enormous capacity to identify novel processes in respiratory medicine and give them original, funny, and noticeably smart names”. In the ‘80s, we used to see patients with overlapping features of asthma and COPD (chronic obstructive pulmonary disease), in whom it was very difficult to figure out which condition prevailed. Since it was impossible to define them in an accurate manner, Alejandro believed that an *ad hoc* neologism could be useful for designating this new chimaera, thus, he started to label them as “bronchastic” and “asthmatic”. That nominative originality, which he showed frequently, came to be accepted in the European and American scientific societies as “asthma-COPD overlap”, with the ACO acronym, a not so funny way of assuming the existence of a hybrid entity in the clinical practice. If only Dr. Raimondi could have read the article published in this RAMR issue...

In this article, Dr. López et al show a secondary analysis of the EPOC.AR study (a population-based survey of national scope) for the purpose of finding an answer to the clinical question regarding the prevalence of asthma and COPD coexistence (ACO) in our country¹. The authors want to measure and weigh this new chimaera. It was found that asthma coexistence was produced in 19.08% of the cases in accordance with the diagnostic criteria of the Denver Agreement². 14.5% of the cases were characterized as ACO only because of the presence of a bronchodilator response between 200 mL and 400 mL, and 4.6% due to the presence

of a previous asthma diagnosis (with or without significant bronchodilator response). Patients with ACO were younger than the rest of the cases and reported more sibilance and more cases with family history of asthma. Also, these patients were receiving inhaled corticosteroids combined with long-acting bronchodilators more frequently, thus suffering more exacerbations and showing repeated absences from work and higher antibiotic consumption. Finally, the pre-bronchodilator lung function was also lower in the ACO group.

The prevalence range found by the authors is below the one reported in COPD studies (between 13% and 55.7%)³. The great variation among the results that can be found in the literature can be attributed to the use of different definitions and diagnostic criteria, and probably to geographical differences and differences in population exposure to risk factors. The reported prevalence of asthma and COPD in our country are within ranges more similar to those from other countries, which leaves us with a question to be further investigated for future studies: to what extent is the underdiagnosis of these diseases influencing the ACO diagnosis? and, what about the fact that eosinophilia wasn't determined in the results?⁴. It seems improbable that the lack of a laboratory minor criterion had a considerable impact on the reported result. On the contrary, its presence could be associated with the eosinophilic variant of COPD.

The results of this study describe a group of people who suffer from a more severe disease, with higher impact on their quality of life, higher frequency of exacerbations, and reduced lung

function. These findings are compatible with an American study that showed that patients with ACO have higher risk of visiting the emergency department and reduced lung function⁵. It would seem that these patients were recognized as asthmatics by their doctors, and treated with inhaled corticosteroids. Unfortunately, there aren't any large, randomized, controlled studies of this subgroup, and recommendations for their treatment are based on expert opinions⁶.

There is much more that we don't know than we do know about ACO. We can't define yet if it is a mere coincidence of two common diseases or a phenotype with a differential behavior. The results of this study at least aim to indicate that the impact on patients who develop an entity with combined features of asthma and COPD is even higher than the one produced by each one of them independently, and is a valuable addition to local knowledge of respiratory medicine. The ACO is not something that was designed in an effort to diagnose, but a real entity with a negative impact on those who suffer from it.

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