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CORRESPONDENCE

Groups C and D have been revised to Group E in the 2023 GOLD report, Have the pieces fallen into place?

Dear Editor,

Global Initiative for Chronic Obstructive Lung Disease (GOLD) has developed common prevention and treatment strategies to improve the management of chronic obstructive pulmonary disease (COPD) worldwide. In this regard, evidence-based recommendations were presented in the annual GOLD strategy report. In the 2023 GOLD report, Groups C and D were merged into a single group 'E' that recognises the clinical relevance of exacerbations, independent of the symptom levels of the patients.[1] This update further enhances the importance of the 'exacerbation history' for pharmacological treatment options.

Treatment recommendations for stable COPD during follow-up were first presented in the 2019 GOLD report, suggesting similar treatment options for patients with frequent exacerbations regardless of symptom status. However, although long-acting muscarinic antagonist monotherapy was recommended as the initial treatment for Group C, different treatment options were recommended for Group D depending on the patient's symptom status and blood eosinophil count.[2] Despite the documented negative effects of exacerbations on the disease prognosis and mortality, the initially recommended monotherapy for patients in Group C was inconsistent with the GOLD goal of preventing future exacerbations. Our article, published in 2021, suggested that the distinction between Groups C and D is not necessary for the initial pharmacological treatment of COPD, and that it would be more appropriate to classify patients with frequent exacerbations into the same group.[3] I believe that all patients in the GOLD 2023 report groups with frequent exacerbations should be classified into one group, which improves patients' access to optimal treatment and physician adherence to the guideline in clinical practice.

Furthermore, as noted by the Lancet COPD Commission,[4] the permanent classification of patients (frequent exacerbator phenotype) based on the improvable and modifiable disease outcomes is inconsistent with Lopez_Campos et al.'s theory[5] They proposed that the clinical phenotype should be a natural manifestation of the disease and that the phenotypic trait should remain stable over time. Is frequent exacerbation of COPD in the previous year a phenotype or only a clinical marker guiding the pharmacologic treatment? It appears that this topic will continue to be debated for the next few years.

Conflicts of interest

The author declares that she has no conflicts of interest in relation to this correspondence.

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