ABSTRACT

Objectives To establish what proportion of patients completing a UK pulmonary rehabilitation (PR) programme meet the 2018 National Institute for Health and Care Excellence (NICE) chronic obstructive pulmonary disease (COPD) guideline (NG115) criteria to have a respiratory review to establish whether referral to a lung volume reduction multidisciplinary team would be appropriate. This respiratory review would include evaluation of the presence of hyperinflation and the presence of emphysema on CT scan. The NICE criteria include measures of breathlessness and exercise capacity but these parameters are not completely defined.

Design Observational study.

Setting PR programmes across the UK in 2015 (210 centres) and 2017 (184 centres) entering data into the Royal College of Physicians’ National Asthma and COPD Audit Programme.

Participants 8295 (55.7%) of 14,889 patients in programmes using incremental shuttle walk test (ISWT) or 6-minute walk test (6MWT) as an outcome measure completed PR, and 4856 (32.6%) had complete data recorded (6MWT/ISWT, baseline spirometry, Medical Research Council (MRC) dyspnoea score).

Results Depending on the walking test safety threshold adopted for the ISWT (≥140 m or ≥ 80 m) and the MRC dyspnoea score threshold used (MRC score ≥3 or ≥4 at the end of PR), between 4.9% and 18.1% of PR completers met the NICE criteria for a lung volume reduction-focused respiratory review.

Conclusions Lung volume reduction therapies are beneficial in appropriately selected patients with COPD, but few procedures are performed, and treatment pathways are unclear. These data help to inform the feasibility of the approach recommended by NICE and highlight the need for future systematic pathways to reduce inequalities in patients being considered for effective treatments.

BACKGROUND

Chronic obstructive pulmonary disease (COPD) is a progressive lung disorder where lung hyperinflation can cause respiratory muscle dysfunction and debilitating breathlessness associated with reduced exercise tolerance, poor quality of life and reduced life expectancy.1-4 Treatment options for this group of patients are limited, and often individuals remain severely burdened by their symptoms despite optimal pharmacological therapy and pulmonary rehabilitation.5 6 Alongside smoking cessation and oxygen therapy, lung volume reduction (LVR) therapies exist as one of a small number of disease-modifying treatments in COPD care.7-10 LVR procedures (surgery or endobronchial valve placement) have been shown to improve dyspnoea, lung mechanics, exercise capacity, quality of life and survival in appropriately selected patients with COPD.11-15 Unfortunately, there has been an absence of formal referral pathways,16 leading to a substantial disparity between the number of people likely to benefit and the number of procedures performed.16-19
Recent UK National Institute for Healthcare Excellence (NICE) guidance (NG115) recommends referral of patients with COPD for a specialist LVR respiratory review to determine the potential eligibility for LVR: if they have a forced expiratory volume in 1 s (FEV₁) <50%, do not smoke, have a 6-minute walk test (6MWT) of ≥140 m and have breathlessness affecting quality of life. This assessment should ideally be undertaken after the completion of pulmonary rehabilitation (PR) which will be a point at which the patient’s functional capacity and management of breathlessness should have been optimised. At this LVR respiratory review, subsequent to PR and depending on the presence of hyperinflation, an appropriate pattern of emphysema on CT and the absence of contraindications (FEV₁ and carbon monoxide transfer factor <20%, significant pulmonary fibrosis, major comorbidity limiting survival), referral to an LVR multidisciplinary team (MDT) to consider technical suitability for LVR is recommended. The NICE recommendation therefore sets out a three-step process (figure 1).

Some questions remain about the NICE criteria. First, the level of breathlessness to trigger consideration of possible LVR is not precisely defined, but typically would be significant self-reported breathlessness (Medical Research Council (MRC) dyspnoea score ≥4) that the patient regards as imposing sufficient lifestyle restriction and symptom burden to warrant consideration of an LVR procedure. However, disability may deteriorate further in the time taken between referral, assessment and investigation at a specialist centre. It may therefore be more appropriate to consider a lower MRC dyspnoea score threshold for initial LVR consideration. Second, the NICE COPD guideline does not provide a safety threshold if the incremental shuttle walk test (ISWT), which is also frequently used to assess exercise capacity at the end of PR, is available rather than the 6MWT.

The primary aim of this study was to assess the proportion of patients with COPD who were appropriate to have an LVR respiratory review (CT scan and full lung function tests) for possible LVR MDT referral at the time of completion of PR and how this varied according to the criteria used to better understand the practicalities of implementing NICE recommendations.

**METHODS**

We pooled data from all patients completing PR, recorded in the UK National Asthma and COPD Audit Programme (NACAP) in 2015 (n=7413) or 2017 (n=7476) (table 1). Based on NICE guideline (NG115) recommendations, we first investigated what proportion would be eligible if criteria included patients with an MRC dyspnoea score ≥4, FEV₁ <50% predicted, and a 6MWT or ISWT of ≥140 m, who were not current smokers. In the absence of an agreed LVR safety threshold for ISWT, we used (1) ≥140 m based on the same distance as the 6MWT and (2) ≥80 m based on the equivalent 6MWT and ISWT thresholds in the multidimensional BODE/iBODE prognostic indices, respectively. We then relaxed the criteria and looked at the same variables but including all with MRC dyspnoea score ≥3.

**Patient and public involvement**

The focus of this research was developed following thematic analysis of patient focus groups conducted in
2016. Patients and public were not involved directly in the design and execution of this analysis of data from the UK NACAP PR audit. Ethical approval was not required for this specific analysis as patient consent was obtained at the time of original data collection. The data set was anonymised prior to being provided to the research team.

RESULTS
In all, 8295 (55.7%) of 14889 patients (table 1) in programmes using ISWT or 6MWT as an outcome measure completed PR, and 4856 (32.6%) had complete data recorded (6MWT/ISWT, baseline spirometry, MRC dyspnoea score). Of those who completed PR with all required data recorded, 238 (4.9%) were eligible for LVR assessment, based on NICE criteria with an MRC dyspnoea score ≥4 (figure 2). This estimate used the same numerical threshold for the ISWT as the 6MWT (≥140 m). Using instead the equivalent iBODE score criterion (≥80 m) for ISWT cut-off, we found that up to 310 patients (6.4%) were eligible. If the criteria were relaxed to include MRC dyspnoea score ≥3, 763 (15.7%) would be eligible based on an ISWT of ≥140 m or 881 (18.1%) based on an ISWT of ≥80 m.
DISCUSSION

These data indicate that between 4.9% and 18.1% of people with COPD completing PR may be eligible for an LVR respiratory review to consider onward referral to an LVR MDT. This proportion varies mainly according to the threshold MRC dyspnoea score set for breathlessness and, to a lesser extent, depending on what ISWT distance is chosen to match the NICE recommendation to include a 6MWT of ≥140 m as a safety criterion. The proportion of individuals who fail to complete PR suggests that careful consideration should be given as to whether PR discharge is the most suitable or only time point for assessing eligibility for LVR.

As this study used data from a national audit, these findings can be assumed to be representative of the UK population and therefore provide a reasonable estimation of the proportion of patients who may be eligible for consideration. However, it is important to note that other factors that might influence decision-making such as the presence of comorbidities and of course patient preference were not recorded. Not all these individuals would be suitable for an LVR respiratory review, and only a proportion of these would be likely to be referred to an LVR MDT. The data do suggest that a systematic approach could significantly reduce current inequalities in access to this form of treatment.

Current NICE guidance proposes that patients should be considered for LVR referral on completion of a PR programme, as following this intervention patients should be optimised. A failure to complete PR is associated with worse long-term outcomes and non-completion is common, approximately 38% between assessment and completion in NACAP data, which may be due to issues unrelated to individual fitness such as transport or location of programmes. Patients with more severe breathlessness who may derive more symptomatic benefit from LVR may be more likely to drop out or may not be able to train at sufficient intensities to bring about improvement through PR and therefore may find the exercise very uncomfortable. Beginning consideration for possible LVR referral at PR assessment may help to promote programme adherence and affords the opportunity to gather other data on comorbidities and previous investigations which may be relevant.

In 2017, we published a qualitative study looking at patient experience of LVR services from referral through to discharge. Results from two focus groups highlighted the difficulties they faced when trying to access LVR centres, with patients reporting their ‘fight’ to get a referral, one aspect of the unmet need which is common in respiratory disease. That article focused only on those patients who received LVR intervention and did not account for all those patients who were excluded from consideration for these important treatments because of the inequalities that exist in referral pathways. Selection criteria should identify people who meet the criteria for LVR and would benefit from a procedure but who are not at an unacceptably high risk of a poor outcome. Further research is needed to develop more systematic patient pathways to identify these individuals.

Routine assessment of eligibility for LVR referral could be considered as an opportunity to improve standards of care for all patients with COPD. Importantly, the present data do not indicate that this proportion of patients should be referred to a specialist centre,

![Figure 2](image-url)
but rather that every patient should be systematically reviewed to consider LVR referral and necessary investigations carried out to evaluate their eligibility, should they express an interest. Future research should focus on the development and refining of LVR referral pathways that can be practically implemented at an appropriate time point and setting.

CONCLUSION

Given the well-established benefits of LVR procedures in appropriately selected patients, these data provide information on the scale of activity that referral pathways will need to accommodate and how these are affected depending on the precise selection criteria used. Raising the potential to be considered for LVR with patients at the point of referral to PR may encourage programme adherence, thus improving health outcomes. Furthermore, linking LVR and PR pathways more formally may also help promote PR referral.19

Twitter Sara C Buttery @SaraButtery, Adam Lewis @apl104 and Nicholas S Hopkinson @COPDdoc

Contributors SCB, MS, JKD and NSH developed the original idea for the research study. SCB and AL collected the data and analysed them with statistical support from WB. SCB produced the first draft. All authors edited and contributed to the final manuscript.

Funding SCB is funded by a grant from the National Institute for Health Research, through the Research for Patient Benefit scheme (PB-PG-1014-35051).

Competing interests SCB, AL, NSH and WB have no competing interests to declare. SVK reports other relationship with PulmonX during the conduct of the study and personal fees from Boston Scientific, outside of the submitted work. JQ declares. SVK reports grants from the RCP during the conduct of the study and personal fees from Boehringer-Ingelheim, outside the submitted work.

Patient and public involvement Patients and/or the public were not involved in the design, conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data may be obtained from a third party and are not publicly available. Data from NACAP can be obtained by application to the Healthcare Quality Improvement Partnership (HQIP) https://www.hqip.org.uk/ national-programmes/accessing-nacap-data/#XsFPja779M.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iDs Sara C Buttery http://orcid.org/0000-0001-9410-414X
Adam Lewis http://orcid.org/0000-0002-0576-8823
Jennifer K Quint http://orcid.org/0000-0003-0149-4869
Nicholas S Hopkinson http://orcid.org/0000-0003-3235-0454

REFERENCES

1. Celli BR, MacNee W, ATS/ERS Task Force. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. Eur Respir J 2004;23:932–46.
2. Moore AJ, Soler RS, Cetti EJ, et al. Sniff nasal inspiratory pressure versus IC/TLC ratio as predictors of mortality in COPD. Respir Med 2010;104:1319–25.
3. Hopkinson NS, Shanshar T, Ross ET, et al. Corticospinal control of respiratory muscles in chronic obstructive pulmonary disease. Respir Physiol Neurobiol 2004;141:1–12.
4. Kelly JL, Elkin SL, Fluxman J, et al. Breathlessness and skeletal muscle weakness in patients undergoing lung health screening in primary care. COPD 2013;10:40–54.
5. Kelly JL, Bamsey O, Smith C, et al. Health status assessment in routine clinical practice: the chronic obstructive pulmonary disease assessment test score in outpatients. Respiration 2012;84:193–9.
6. Philip K, Gaduzo S, Rogers J, et al. Patient experience of COPD care: outcomes from the British Lung Foundation patient Passport. BMJ Open Respir Res 2019;6:e000478.
7. Hopkinson NS, Molynieux A, Pink J, et al. Chronic obstructive pulmonary disease: diagnosis and management: summary of updated NICE guidance. BMJ 2019;368:k4846.
8. Criner GJ, Cordova F, Sterberg AL, et al. The functional emphysema treatment trial (NETT) part II: lessons learned about lung volume reduction surgery. Am J Respir Crit Care Med 2011;184:881–93.
9. Gompelmann D, Benjamin N, Bischoff E, et al. Survival after endoscopic valve therapy in patients with severe emphysema. Lancet Respir Med 2019;7:112–20.
10. Garner J, Kemp SV, Toma TP, et al. Survival after endobronchial valve placement for emphysema: a 10-year follow-up study. Am J Respir Crit Care Med 2016;194:519–21.
11. Zoumot Z, Jordan S, Hopkinson NS. Emphysema: time to say farewell to therapeutic nihilism. Thorax 2014;69:573–5.
12. van Geffen WH, Slebos D-J, Herrij FJ, et al. Surgical and endoscopic interventions that reduce lung volume for emphysema: a systemic review and meta-analysis. Lancet Respir Med 2019;7:313–24.
13. Faisal A, Zoumot Z, Shah PL, et al. Effective bronchoscopic lung volume reduction accelerates exercise oxygen uptake kinetics in emphysema. Chest 2016;149:435–46.
14. Zoumot Z, LoMauro A, Aliverti A, et al. Lung volume reduction in emphysema improves chest wall asynchrony. Chest 2015;148:85–95.
15. Hopkinson NS. Bronchoscopic lung volume reduction: indications, effects and prospects. Curr Opin Pulm Med 2007;13:125–30.
16. McNulty W, Jordan S, Hopkinson NS. Attitudes and access to lung volume reduction surgery for COPD: a survey by the British thoracic Society. BMJ Open Respir Res 2014;1:e000023.
17. Whittaker HR, Connell O, Campbell J, et al. Eligibility for lung volume reduction surgery in patients with COPD identified in a UK primary care setting. Chest 2020;157:276–85.
18. Clark SJ, Zoumot Z, Bamsey O, et al. Surgical approaches for lung volume reduction in emphysema. Clin Med 2014;14:122–7.
19. Hopkinson NS. Lung volume reduction: apex treatments and the ecology of chronic obstructive pulmonary disease care. Am J Respir Crit Care Med 2019;200:1329–31.
20. Royal College of Physicians. Pulmonary rehabilitation: beyond breathing better, 2017. Available: https://www.rcplondon.ac.uk/projects/outputs/pulmonary-rehabilitation-beyond-breathing-better
21. Williams JEA, Green RH, Warrington V, et al. Development of the i-BODE: validation of the incremental shuttle walking test within the BODE index. Respir Med 2012;106:390–6.
22. Buttery S, Lewis A, Oey I, et al. Patient experience of lung volume reduction procedures for emphysema: a qualitative service improvement project. ERJ Open Res 2017;3:00031-2017
23. Lindenauer PK, Stefan MS, Pekow PS, et al. Association between initiation of pulmonary rehabilitation after hospitalization for COPD and 1-year survival among Medicare beneficiaries. JAMA 2020;323:1813–23.
24. Boutou AK, Tanner RJ, Lord VM, et al. An evaluation of factors associated with completion and benefit from pulmonary rehabilitation in COPD. BMJ Open Respir Res 2014;1:e000051.
25. Ward TJG, Plumptre BD, Dohmage TE, et al. Change in VO2peak in response to aerobic exercise training and the relationship with exercise prescription in people with COPD: a systematic review and meta-analysis. Chest 2020.
26. Elbehairy AF, Quint JK, Rogers J, et al. Patterns of breathlessness and associated consulting behaviour: results of an online survey. Thorax 2019;74:814–7.
27. Greening NJ, Vaughan P, Oey I, et al. Individualised risk in patients undergoing lung volume reduction surgery: the Glenfield BFG score. Eur Respir J 2017;49:1801766.