To the Editor: In 2017, the Global Initiative for Chronic Obstructive Lung Disease (GOLD) released a total revised document (GOLD 2017),[1] in which one important change is the “ABCD” classification for the management of patients with chronic obstructive pulmonary disease (COPD). The assessment tool of the GOLD 2011 combined the symptomatic assessment with the patient’s spirometric classification and/or risk of exacerbations, and the revised GOLD 2014,[2] added the history of hospitalization due to an exacerbation in the preceding year as a method of assessing exacerbation risk. However, increasing evidence suggested the limitations of the forced expiratory volume in 1 s (FEV1) in influencing prognostic and therapeutic decisions. The new GOLD 2017 classification separates spirometric grades from the “ABCD” groups.[1] To date, the impact of this revision on grouping and subsequent drug selection has been insufficiently studied.

Recently, a multicenter, observational, and cross-sectional study was conducted to compare the effects of the GOLD 2014 and 2017 on the grouping and treatment of COPD patients in Hunan, China. All data were obtained from the records of clinically stable outpatients aged >40 years in 2016 and 2017 with COPD, according to the diagnostic criteria of the GOLD 2017. Patients with other active or chronic respiratory diseases that needed to be diagnosed, intervened, or treated were excluded.

In 561 COPD patients, the distributions from Groups A to D were 17 (3.0%), 147 (26.2%), 6 (1.1%), and 391 (69.7%) to 19 (3.4%), 280 (49.9%), 4 (0.7%), and 258 (46.0%), according to the GOLD 2014 and 2017, respectively. The new classification led to a decrease in the use of ICS. As a result, ICS-related complications, such as pneumonia and pulmonary tuberculosis, can be reduced. According to the new GOLD 2017, ABCD groups will be derived exclusively from patient symptoms and their history of exacerbation, which seems to be on the way to individualized medicine and may improve the prognosis. Of note, in China, patients often refuse to seek medical help until severe symptoms appear. This led to the limited number of patients in Groups A and C in this study. Another reason was that patients with a COPD Assessment Test (CAT) score ≥10 and Modified British Medical Research Council grade ≥2 accounted for 95.9% and 64.5%, respectively. Most patients were divided into Groups B and D because of higher CAT scores. Several studies have found that lung function and previous exacerbation history were different in predicting prospective exacerbation rates, and the exacerbation history was the best predictor.[3] A large sample size study is needed to further research whether the revised classification significantly decreases the proportion of patients in high-risk groups, which also affects the therapeutic decisions to a lesser degree. The regrouping may lead to a decrease in the use of ICS. As a result, ICS-related complications, such as pneumonia and pulmonary tuberculosis, can be reduced.

In conclusion, the new classification separates spirometric grades from the “ABCD” groups.[1] To date, the impact of this revision on grouping and subsequent drug selection has been insufficiently studied.
ABCD categories provide any prognostic information on disease progression over time.

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Conflicts of interest
There are no conflicts of interest.

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