The Relationship between COPD Assessment Test (CAT) Scores and Severity of Airflow Obstruction in Stable COPD Patients

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INTRODUCTION

Chronic obstructive pulmonary disease (COPD) is a progressive condition leading to morbidity and mortality and is characterized by cough, dyspnea and sputum production. COPD is a condition with persistent airflow limitation and systemic inflammation affecting the lungs and other organs and impairing quality of life by several mechanisms (1-3).

Although the severity of airflow obstruction is evaluated by forced expiratory volume in one second (FEV1), this test does not show the multidimensional effect of systemic inflammation on health status (4, 5). On the other hand, COPD is a complex disease with...
multiple consequences including breathlessness, exercise limitation, muscle wasting, weight loss, increased hypercoagulability, depression, coronary artery disease and other systemic inflammatory effects (6,7).

Recently a new simple system evaluating health status was approved to evaluate the impact of COPD on health status (8). The COPD Assessment Test (CAT) is a new scoring system for COPD patients, which provides a simple method for assessing the impact of COPD on the patient’s health. The validation studies have shown that it has similar properties as St. George’s Respiratory Questionnaire (SGRQ) (9-11).

The CAT and FEV₁ are complementary measurements for assessment and management of COPD (9,10). The CAT is a standard and validated test containing eight items for the evaluation of the impact of COPD on health status (8,9). It is a tool for the measurement of disease impact on health status, but FEV₁ is essential to establish a diagnosis and to confirm the severity of airway obstruction in symptomatic COPD patients (5).

The CAT and FEV₁ are both reliable methods for assessing the treatment response and progression of disease severity in COPD patients (10).

In some studies FEV₁ was poorly correlated with quality of life, yet several researchers have reported a weak correlation between health status score and FEV₁ (10).

The aim of this study was to evaluate the correlation between airflow obstruction by FEV₁ and Global initiative for Obstructive Lung Disease (GOLD) classification and health status of COPD patients by CAT score and CAT groups.

**MATERIALS AND METHODS**

Between March 2010 and April 2011 a total of 105 COPD patients of various severity were enrolled in this cross-sectional study in Imam Khomeini Hospital of Ardabil University of Medical Sciences. All patients received the optimal treatment according to the GOLD classification.

The diagnosis of COPD was established based on a medical history of smoking, current symptoms of cough, dyspnea or sputum production and available standard pulmonary function test which was performed by a spirometer (Chest Inc., 801, Tokyo, Japan) according to the ATS standards (American Thoracic Society). In case of disparity between the clinical criteria and the ATS standards, a preference was given to clinical criteria. The severity of COPD was assessed according to GOLD classifications as follows:

- Stage 0 (at risk), stage 1 (mild), stage 2 (moderate), stage 3 (severe) and stage 4 (very severe).

All patients were clinically stable during the past four weeks. The exclusion criterion was presence of an illness other than COPD such as bronchial asthma, tuberculosis, bronchiectasis, ischemic heart disease or malignancy.

This study was approved by the Institutional Ethics Committee and all patients provided written informed consent.

**CAT score**

After history taking and physical examination, all patients completed the Persian version of CAT respiratory questionnaire.

The total CAT score was calculated for each individual by summing the points for each variable.

CAT has a scoring range of zero to 40. The CAT score was classified into four groups of low(1), medium(2), high(3) and very high(4) based on the impact level of disease on health status as shown in Table 1.

| CAT score | Impact level |
|-----------|--------------|
| < 10      | Low          |
| 10 – 20   | Medium       |
| 21 - 30   | High         |
| > 30      | Very high    |

| Table 1. Impact level of COPD on health status. |
Analysis

Data were described as means ± standard deviation. Differences between means were tested with student’s t-test and reported with 95% confidence interval (95% CI).

The correlation between the CAT score and GOLD classification was tested by one way ANOVA. In order to evaluate the correlation between parametric variables, the Pearson’s correlation coefficient was utilized. Data analysis was performed using SPSS version 16 software. P<0.05 was considered statistically significant.

RESULTS

A total of 105 male patients were included in this study. General characteristics of these patients are shown in Table 2.

Table 2. General characteristics of patients.

| General Characteristics | Data |
|-------------------------|------|
| Male (No.)              | 105  |
| Age, years              | 59.60±11.93 |
| FEV1%predicted          | 71.01±26.70 |
| FVC%predicted           | 91.39±27.45 |
| FEV1 / FVC              | 61.10±13.05 |
| Total CAT score         | 19.61±8.07 |
| Smoking, PY             | 35.43±15.33 |

Values are presented as means ± standard deviation

The mean CAT score was 19.61±8.07 SD with a minimum score of 2 and a maximum score of 34. The correlation between the number of patients in stage 0 to stage IV of COPD severity by GOLD classification and their mean CAT score in each stage was statistically significant (P<0.001) as shown in Table 3.

Table 3. Correlation between the number of patients in stage 0 to stage IV of COPD severity by GOLD classification and their mean CAT score

| GOLD | GOLD | GOLD | GOLD | GOLD |
|------|------|------|------|------|
| 0    | I    | II   | III  | IV   |
| Number of patients | 17 | 22 | 39 | 22 | 5 |
| CAT score | 13.12 | 14.55 | 21.08 | 25.09 | 28.40 |
| P value | P<0.001 |

The mean age of patients and the mean period of smoking pack/year (P/Y) were 59.60±11.93 and 35.43±15.3, respectively. The mean FEV1%predicted was 71.01±26.70 and the mean FVC%predicted was 91.39±27.45, respectively. The mean FEV1/FVC was 61.10±13.05.

The correlation between FEV1 value and total CAT score was significant (r= -0.55, P<0.001). The correlation between total score of CAT and FVC%predicted was significant as well (r= -0.49, P<0.001).

The amount of smoking by P/Y increased significantly with higher GOLD classification stages (P=0.006) and the differences between the stage II, and stage III and IV (P=0.003 and P=0.05 respectively) were statistically significant but no differences were noticed between stage I and II by GOLD classification (P=0.65).

The correlation between the CAT score and amount of smoking by P/Y appeared to be significant (P<0.001, r= 0.35). The correlation between FEV1%predicted and amount of smoking by P/Y was found to be statistically significant as well (P=0.007).

The comparison of mean FEV1%predicted with mean score of CAT groups 1 (low impact level) to 4 (very high impact level) were 90.15±21.11, 81.52±24.05, 61.15±24.50 and 46.91±16.38 respectively (P<0.001).

The mean FEV1/FVC in the CAT groups 1, 2, 3, and 4 was 64.46±11.37, 65.25±12.74, 59.05±13.03 and 49.73±7.82, respectively (P<0.001).

DISCUSSION

COPD is a systemic disease with airflow obstruction, systemic inflammation, multi-organ damage and impairment (1). This study demonstrated that CAT questionnaire which is a patient-completed instrument for estimating the impact of COPD on health status has a better correlation with severity of airflow obstruction by FEV1 in stable COPD patients.

COPD is a complex multidimensional disease that affects the lungs as well as other organs through
chronic systemic inflammation and increased inflammatory markers that do not correctly address the severity of airflow limitation.

In this study, no differences were found between CAT score of male and female patients. This fact may be due to the nature of COPD that is not influenced by gender and the major risk factor of disease is smoking. This is in line with some previous researches (10,12,13).

We found that FEV1/predicted and FEV1/FVC were reduced in COPD patients and the correlation of smoking with airflow limitation is in concordance with previous researches.

Airflow obstruction as measured by FEV1 in symptomatic patients is a diagnostic tool but it is not suitable for monitoring disease progression. However, the FEV1 does not adequately reflect all the systemic manifestations of COPD patients. It is an important assay for staging of COPD (4,5).

CAT is not a diagnostic tool but it can identify the health impairment of COPD patients and is better correlated with disease progression.

The multiple consequences of COPD have no relationship with airflow limitation and FEV1 cannot reflect the total impairment caused by the disease. Some patients experience improvement in health status without change in their FEV1 after optimal treatment for COPD (5).

Several studies have shown weak correlation between FEV1 and health status questionnaire. Other researchers showed that the health status was only weakly correlated with the decline in FEV1.

Our findings confirm that airflow limitation increased with disease severity is better accompanied by increasing CAT scores.

We observed that health status decline evaluated by CAT is correlated with the decline of airflow obstruction and patients with more severe COPD (as defined by FEV1) had higher CAT scores (10).

One of the most important findings of the current study is the inverse correlation between FEV1 and CAT groups. These results suggest that a lower FEV1 indicates high CAT score and health impairment due to COPD (Figure 1).

![Figure 1. Correlation between FEV1 and CAT groups.](image1)

Results for CAT score and GOLD classification revealed a strong positive correlation between the tests (Figure 2).

![Figure 2. Correlation between CAT score and Gold classification.](image2)

The present study suggests that COPD severity assessed by the CAT score can be directly related to airflow limitation. On the other hand, the CAT questionnaire can be employed as a predictor of severity of airway obstruction in COPD patients.
It was also observed that the period of smoking (P/Y) is inversely correlated with FEV₁ as the most important risk factor for COPD.

Our study had some limitations. The first limitation was the lack of serum level of inflammatory markers and other physiologic parameters such as Modified Medical Research Council (MMRC) and 6-minute walking distance (6MWT) to evaluate the correlation of these parameters with CAT score and airflow obstruction. Secondly, our sample size was relatively small.

In conclusion, this study supported the hypothesis that there is a correlation between airflow limitation and health status questionnaires like CAT. FEV₁ is essential for diagnosis of the respiratory impairment resulting from COPD but, the CAT is not a diagnostic tool in COPD patients. However, in previously diagnosed COPD patients the CAT is a better assay for evaluating the severity of disease, management of patient response to treatment and prognosis. Finally, it is likely that airflow limitation and systemic alteration in COPD both happen in one inflammatory environment.

Conflict of Interest: the authors report no conflict of interns in this work.

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