Capsule Commentary on Griffith et al., Overuse and Misuse of Inhaled Corticosteroids Among Veterans with COPD: a Cross-Sectional Study Evaluating Targets for De-implementation

Joseph Barney, MD MSPH

University of Alabama at Birmingham, Birmingham, USA.

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This work by Griffith and colleagues is an elegant approach to what is considered by many as a clumsy and maladroit dilemma in medicine, reassessing our perspectives on overdoing potentially harmful medical therapies. While the population is somewhat homogenous, predominantly male VA patients, the authors found wide variance in prescribing patterns and problems with adhering to guidelines in use of inhaled corticosteroids among patients diagnosed with COPD. Corticosteroids are often overused among primary care providers for both asthma and COPD due to lack of knowledge of potential harms and pressures from patients presenting with dyspnea to "do something" which translates to prescribing something.[1] Not only can inhaled corticosteroids lead to increased rates of pneumonia; certain combinations have been associated with higher rates of sepsis, bacteremia, and skin infections among patients with COPD.[2–4]

Questions that arise from this research include the following: Can we systematically enhance primary care providers' knowledge and experience with COPD management and align prescribing practice with more rigorous disease phenotypes while offering an algorithm of options for treatment for patients with dyspnea from other comorbidities? Can we build an educational program that is broadly generalizable to wide sectors of the population where pharmaceutical influence has traction and seeks to sell prescriptions? Can we make this approach of scientific de-escalation of therapy intriguing enough to the gatekeepers that they become invested in it with as much equity as the authors that shepherd the work?

Corresponding Author: *Joseph Barney, MD MSPH; University of Alabama at Birmingham, Birmingham, USA (e-mail: Jbarney@uabmc.edu).*

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