Arista|MD

Consult Request

SPECIALTY

Pulmonology

CHIEF COMPLAINT

COPD

COMMENTS TO SPECIALIST

84-year-old female with COPD, morbid obesity, chronic hypoxic respiratory failure on 2L NC, congestive heart failure with reduced ejection fraction (HFrEF) w/Mitral regurgitation and tricuspid regurgitation (MR/TR) and Ejection fraction (EF) 42%. Worsening dyspnea is associated with expiratory wheezes, O2 sat at baseline on 2L NC, and a globular filtration rate (GFR) of 55, which is normotensive.

Chest radiography (CXR) showed cardiomegaly and vascular congestion. On Lasix 40 mg and Aldactone 25 mg daily added for worsening dyspnea. Her daily COPD maintenance regimen consists of Prednisone 5 mg, Singulair 10 mg, and Incruse 62.5 mg. Received IM solumedrol and started on high-dose prednisone taper, Xopenex QID, inhaled budesonide BID x 7 days. IV was placed for IV cefepime, given left shift on complete blood count (CBC).

MAIN QUESTION

How can I optimize her respiratory regimen while awaiting a pulmonary medicine appointment and potentially a sleep study?

Specialist Response

SUMMARY

Treatment options are available at the primary care level.

DETAILS

I was reassured that her volume status is not contributing to her respiratory distress since she does not appear to have crackles and is euvolemic. I don't feel there is a degree

of asthma/COPD overlap, given that she lives on prednisone and is on Singulair since those medications are less commonly used in COPD.
I recommend the following:

- • Consider adding an inhaled corticosteroid (ICS)/long-acting beta agonist (LABA) to her inhaler regimen since Incruse may not be enough. Consider Trelegy, if covered by insurance, but if not, you can add Breo to Incruse for triple med therapy. Continue budesonide nebs until a new regimen can be started
- Agree with albuterol xopenex nebs four times a day (QID) or every four hours if the facility can (while the patient is awake).
- Add 500 mg of azithromycin x 1, then 250 mg daily x 4 days for a total of 5 days.
- Azithromycin has an anti-inflammatory component and has been shown to benefit patients with COPD exacerbation.
- Consider increasing the steroid dose to 40-60 mg for 5 days, then follow your planned taper from there, assuming no blood sugar concerns.
- If chest X-rays do not show pneumonia, I'll defer whether cefepime is necessary. The left shift on the CBC differential could be due to the steroids.
- Given her body habitus and comorbid conditions, she is at high risk for Obstructive Sleep Apnea, which, if left untreated, can contribute to a lack of control of her heart and lung disease. Agree that a sleep study would be beneficial.