**IMPORTANCE** Chronic obstructive pulmonary disease (COPD) is a leading cause of morbidity and mortality in the US.

**OBJECTIVE** To conduct a targeted systematic review to update the evidence on the effectiveness of screening for COPD and the treatment of COPD to inform the US Preventive Services Task Force (USPSTF) update of the 2016 recommendation statement on COPD screening.

**DATA SOURCES** MEDLINE, the Cochrane Central Register of Controlled Trials, and CINAHL for relevant studies published between January 1, 2015, to January 22, 2021; surveillance through March 25, 2022.

**STUDY SELECTION** English-language studies of screening in individuals who do not recognize or report respiratory symptoms; studies of treatment in persons with mild or moderate, or minimally symptomatic, COPD.

**DATA EXTRACTION AND SYNTHESIS** Two reviewers independently appraised the articles and extracted relevant data from fair- or good-quality studies; no quantitative synthesis was conducted.

**MAIN OUTCOMES AND MEASURES** COPD-related morbidity or mortality, measures of health-related quality of life, and adverse events.

**RESULTS** The review included no trials on the effectiveness of screening, 3 trials or analyses (n = 20 058) of pharmacologic treatment published since 2015, 13 trials (n = 3657) of nonpharmacologic interventions, and 2 large observational studies (n = 243 517) addressing the harms of pharmacologic treatment published since 2015. The results from the clinical trials of pharmacologic therapy are consistent with the previous review supporting the USPSTF that bronchodilators with or without inhaled corticosteroids can reduce COPD exacerbations and tiotropium can improve health-related quality of life in adults with moderate COPD. Overall, there was no consistent benefit observed for any type of nonpharmacologic intervention across a range of patient outcomes. None of the included treatment trials that reported adverse effects found significant harms. Two large observational studies in a screen-relevant population demonstrated an association of the initiation of a long-acting muscarinic antagonist or long-acting beta agonist with the risk of a serious cardiovascular event in treatment-naïve patients and an association of inhaled corticosteroids use with the risk of developing diabetes.

**CONCLUSIONS AND RELEVANCE** The findings of this targeted evidence update are generally consistent with the findings of the previous systematic review supporting the 2016 USPSTF recommendation. Evidence of pharmacologic treatment was still largely limited to persons with moderate airflow obstruction, and there was no consistent benefit observed for a range of nonpharmacologic interventions in mild to moderate COPD or in minimally symptomatic persons with COPD.
Chronic obstructive pulmonary disease (COPD) is defined by a reduction in airflow that is not entirely reversible. COPD remains a leading cause of morbidity and mortality in the US. The major risk factor for developing COPD and COPD mortality is exposure to smoke or fumes, notably direct or indirect exposure to cigarette smoke, and occupational or environmental exposures (eg, pollutants, wood smoke). Many patients with COPD go undetected for multiple reasons, including underrecognition of mild symptoms (eg, dyspnea) or nonspecific symptoms (eg, fatigue). Screening or active case finding (ie, spirometry based on systematically assessing for symptoms, risk factors, or both) for COPD can detect persons otherwise not diagnosed as part of routine care; however, it is yet unclear if increased detection of persons with unrecognized symptoms improves patient health outcomes.

In 2008, and again in 2016, the US Preventive Services Task Force (USPSTF) issued a D recommendation against screening for COPD in asymptomatic adults (defined as individuals who do not recognize or report respiratory symptoms). Although prior evidence demonstrated that screening could identify adults with COPD, there was no direct evidence that screening for COPD improved patient outcomes and limited treatment evidence to suggest a clinically meaningful benefit in persons considered to be most applicable to a screen-detected population. Using the USPSTF reaffirmation process, this targeted evidence update aimed to update the evidence on the effectiveness of screening for COPD and the treatment of COPD since 2015.

Methods

An analytic framework and 3 key questions (KQs) guided the evidence update (Figure). Detailed methods and results of this systematic review are available in the full evidence report.

A literature search of MEDLINE, the Cochrane Central Register of Controlled Trials, and CINAHL was conducted from January 1, 2015, to January 22, 2021. Because the previous review did not include nonpharmacologic interventions, these searches were supplemented by examining reference lists of recent reviews and primary studies, and citations provided by experts, to identify major studies published prior to 2015. ClinicalTrials.gov and the World Health Organization International Clinical Trials Registry Platform were searched for ongoing trials. Since January 2021, ongoing surveillance to identify new studies that might affect the review conclusions or interpretation of the evidence was conducted using article alerts and targeted searches of journals with high impact factors. The last surveillance, conducted on March 25, 2022, identified no new studies that would meet inclusion criteria for this review.

To address KQ1 on the effectiveness of screening or risk-tailed screening (referred to as active case finding) for COPD on health outcomes, the review included randomized clinical trials of any screening method (eg, spirometry, questionnaire, or risk assessment followed by spirometry) in asymptomatic adults, adults who have symptoms undetected by the patient or clinician.
Table. Comparison of Foundational and New Evidence: Screening and Treatment for Chronic Obstructive Pulmonary Disease

<table>
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<tr>
<th>Evidence summary in 2016</th>
<th>New evidence findings</th>
<th>Limitations of new evidence</th>
<th>Consistency of new evidence with foundational evidence and current understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective screening</td>
<td>No trials identified</td>
<td>No trials identified</td>
<td>NA</td>
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**Benefit of pharmacologic treatment**
- 14 RCTs (n = 12,846)
- Evidence largely among individuals with moderate COPD
- Only consistent benefit observed was reduced COPD exacerbations with no consistent benefits in mortality, dyspnea, or health-related quality of life
- 3 RCTs (n = 20,058)
- Bronchodilators and inhaled corticosteroids can reduce COPD exacerbations in persons with moderate COPD
- In a small subgroup analyses from 1 trial (n = 357), LAMA (ie, tiotropium) reduced exacerbations in minimally symptomatic persons with moderate airflow obstruction
- Limited evaluation of pharmacologic therapies in “screen-relevant” populations
- Generally consistent for limited benefit of bronchodilators and inhaled corticosteroids for reduction in exacerbation outcomes
- Evidence is primarily in individuals with moderate COPD, leading to unclear wider applicability to screen-detected persons with COPD
- Signal for benefit of tiotropium on exacerbations in minimally symptomatic persons

**Harms of pharmacologic treatment**
- 8 RCTs (n = 10,368)
- Overall, limited data on serious harms reported in included treatment trials suggested no substantial serious adverse effects for most bronchodilators and inhaled corticosteroids
- 3 RCTs and 2 observational studies (n = 242,588)
- Initiation of a LAMA or LABA is associated with an increase in risk of serious cardiovascular events, and inhaled corticosteroids are associated with an increase in risk of developing diabetes
- Harms not consistently reported in trials of pharmacologic interventions
- Treatment trials are limited in their ability to detect uncommon or longer-term harms
- Consistent for no serious harms from treatment trials, but large observational studies in screen-relevant populations suggest possible harms for LAMA or LABA initiation or use of inhaled corticosteroids

**Benefit of nonpharmacologic treatment**
- NA
- 13 trials (n = 3,658)
- No consistent benefit for a range of nonpharmacologic interventions observed across multiple outcomes
- Trials were generally small, had usual comparator groups in settings that may provide more care than typically received in the US, and/or had suboptimal uptake of the intervention
- NA

**Harms of nonpharmacologic treatment**
- NA
- 3 trials (n = 929)
- Self-management intervention trials did not demonstrate any serious harms
- Harms not consistently reported in trials of nonpharmacologic interventions
- NA

Abbreviations: COPD, chronic obstructive pulmonary disease; LABA, long-acting beta-agonist; LAMA, long-acting muscarinic antagonist; NA, not applicable; RCT, randomized clinical trial.

Results

We screened 6387 titles and abstracts and 229 full-text articles. As in the previous review for the USPSTF, we identified that directly examined the effectiveness of screening or active case finding for COPD on health outcomes (KQ1). Sixteen trials evaluating the treatment of mild to moderate, or minimally symptomatic, COPD were identified, including 3 trials (n = 20,058) published since 2015 evaluating pharmacologic therapy and 13 trials (n = 3657) evaluating nonpharmacologic interventions (ie, self-management interventions, exercise counseling interventions, supervised exercise and pulmonary rehabilitation interventions, and clinician education interventions) (KQ2). Two large observational studies (n = 243,517) published since 2015 addressed harms of pharmacologic treatment (KQ3).

Three studies were identified since 2015 with newly published analyses of pharmacologic treatment in mild to moderate COPD, or in minimally symptomatic persons (ie, GOLD category A), since the 2016 review. Overall, the results from the clinical trials of pharmacologic therapy are consistent with the previous review’s findings that bronchodilators with or without inhaled corticosteroids can reduce COPD exacerbations and tiotropium can improve health-related quality of life in adults with fairly symptomatic moderate COPD (Table). The Understanding Potential Long-Term Impacts on Function With Tiotropium (UPLIFT) trial (n = 59,993) was included in the previous review but had 2 newly published post hoc subgroup analyses in adults with moderate COPD (stage II) (n = 2603) and minimally symptomatic patients (GOLD category A) (n = 357). The subgroup of individuals with minimal symptoms (ie, GOLD category A) found a reduction in exacerbations with tiotropium at 48 months.

Thirteen trials evaluated nonpharmacologic interventions used in the management of mild to moderate, or minimally symptomatic (GOLD category A), COPD: 7 trials of self-management interventions, 1 trial of exercise-only counseling, 3 trials of...
intensive supervised exercise or pulmonary rehabilitation, and 2 trials of clinician education or training on COPD care. Among these trials no consistent benefit was observed across a range of outcomes (ie, exacerbations, health-related quality of life, dyspnea, exercise or physical performance measures, mental health, smoking cessation) at 26 to 104 weeks (Table). There was limited evidence on the harms of pharmacologic and nonpharmacologic interventions in the treatment of mild to moderate, or minimally symptomatic, COPD. None of the included trials that reported adverse effects found significant harms. In addition to the trial evidence, 2 large observational studies addressing harms of pharmacologic treatment demonstrated that initiation of a long-acting muscarinic antagonist or long-acting beta agonist may increase the risk of serious cardiovascular events in treatment-naive patients and that inhaled corticosteroids may increase the risk of developing diabetes (Table).

Discussion

This review was a targeted evidence update aimed at addressing the interval evidence on key evidence gaps identified in the 2016 USPSTF recommendation on screening for COPD. As such, this review only updated a subset of the key questions previously addressed. As in the previous review, no treatment studies were identified that were conducted in patients with screen-detected COPD, with evidence almost exclusively among individuals with moderate COPD. The only consistent benefit observed was reduced COPD exacerbations with no consistent benefits in mortality, dyspnea, or health-related quality of life. This review contained newly included evidence related to nonpharmacologic treatment. While no consistent benefit was seen among these trials it is unclear if and how small sample sizes, usual care comparators in trials conducted outside the US, and/or poor adherence to the interventions contributed to the largely null findings. In addition, nonpharmacologic intervention and sharing spirometry results (or lung age) have not been found to improve smoking cessation, and data on the uptake of other preventive services (eg, vaccination, lung cancer screening) are limited. In general, harms of pharmacologic and nonpharmacologic interventions were not consistently reported in treatment trials, although large observational studies suggest harms for the initiation of a long-acting muscarinic antagonist or long-acting beta-agonist and the longer-term use of inhaled corticosteroids in persons with COPD.

To date, there are still no completed studies evaluating the effectiveness of screening or active case finding for COPD on patient health outcomes. Currently, there is 1 cluster randomized clinical trial, COPD Assessment in Primary Care To Identify Undiagnosed Respiratory Disease and Exacerbation Risk (CAPTURE), of screening for COPD underway that will provide direct evidence for the effectiveness of screening for COPD in the US. That trial evaluates screening with a 5-item questionnaire and peak flow measurement in persons aged 45 to 80 years in primary care, without any restrictions on smoking history. It has a planned 5-year follow-up and includes outcomes on changes to clinical care, patient symptoms, exacerbations, hospitalizations, and mortality.

Limitations

This review has several limitations. First, this targeted evidence update did not address the screening yield or screening accuracy of various screening or active case-finding approaches. Second, to approximate a screen-detected population, studies of treatment benefits or harms were limited to those in persons with mild to moderate COPD or who were minimally symptomatic (based on GOLD criteria), or studies that reported subgroup analyses in these persons. Third, forced expiratory volume in 1 second was not an included outcome.

Conclusions

The findings of this targeted evidence update are generally consistent with the findings of the previous systematic review supporting the 2016 recommendation. Evidence of pharmacologic treatment was still largely limited to persons with moderate airflow obstruction, and there was no consistent benefit observed for a range of nonpharmacologic interventions in mild to moderate COPD or in minimally symptomatic persons with COPD.

ARTICLE INFORMATION

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Author Contributions: Ms Webber and Dr Lin had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Concept and design: Webber, Lin. Acquisition, analysis, or interpretation of data: All authors. Drafting of the manuscript: Webber. Critical revision of the manuscript for important intellectual content: All authors. Obtained funding: Lin. Administrative, technical, or material support: Webber, Thomas. Conflict of Interest Disclosures: None reported.

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Editorial Disclaimer: This evidence report is presented as a document in support of the accompanying USPSTF Recommendation Statement. It did not undergo additional peer review after submission to JAMA.