**Medical Insider COPD, Season 3
Beating breathlessness: The impact of dyspnoea in COPD**

Richard Russell ([00:00](https://www.rev.com/transcript-editor/Edit?token=z_RDQhtIxcpmfN3GeaqhPdrWwF-a7i-OLP0EZPv5Wjg84yibu1CJrSGt-N40DLHxKpDY88v33I2CV1fNittG3GErOHQ&loadFrom=DocumentDeeplink&ts=0.5)):

This podcast is intended for healthcare professionals outside the United Kingdom and the United States of America only. Welcome to the Medical Insider COPD podcast by Boehringer Ingelheim, a podcast offering a breath of fresh air to clinicians treating COPD across the globe. My name is Dr. Richard Russell, and I'm a Consultant Chest Physician at Lymington New Forest Hospital in United Kingdom. I'm also a Senior Clinical Researcher at the University of Oxford, and it's my pleasure to be the Chief Editor of the *International Journal of COPD*. I'm your moderating host for this season of Medical Insider COPD podcast, and I'm here to bring you news and insights on COPD right from the source to you. Thank you for joining us today. Be sure to subscribe to follow Medical Insider COPD, to ensure that you do not miss any of the exciting podcasts in this series or the ones we've already recorded.

Richard Russell ([01:06](https://www.rev.com/transcript-editor/Edit?token=LCaWCGQft3GRap0ZWxZFj0IWeC_RrrulstYGCDWmNLtrv8zmRmjQITvLgxSwS2YS1TfEga4i0EnCBcYjnrw9df6RIAo&loadFrom=DocumentDeeplink&ts=50.4)):

Today we're going to delve into a publication, which I believe is well worth reading. It's entitled ‘The Impact of Lung Function and Exacerbations on Health-Related Quality of Life in COPD Patients in One Year, A Real-World Analysis.’ We're also going to look at an emerging and important topic on social media for COPD patients. That's wearing masks in COVID and also what they're going to do this winter. But first I'm delighted to introduce today's guest who's going to be here with me to discuss the topic of breathlessness, dyspnoea, in COPD. Welcome Dr. Barbara Yawn. Barbara, please introduce yourself to the audience.

Barbara Yawn ([01:](https://www.rev.com/transcript-editor/Edit?token=ESO09GDeV9446_M-lPLnmep72ylwgYdAAwLG-94Ta8Q6NZq_LiqI1W204M2u83OB9AHqgRvC0T7dax0CiYPQGpGGolw&loadFrom=DocumentDeeplink&ts=88.14)42):

Thank you very much. I'm very pleased to be with you. I am a family physician by training. I had several years of experience in rural practice and then have been doing clinical research for many years. I founded the research department at the Olmsted Medical Center, which I've now retired from. I also have been Chief Clinical Officer of the COPD Foundation, and I am the Editor in Chief of *Respiratory Medicine Case Reports*. So, I am very pleased to be with you today and continue to be very interested in COPD and asthma and respiratory illnesses as they're cared for by both primary care and specialists.

Richard Russell ([02:30](https://www.rev.com/transcript-editor/Edit?token=o5vkrZGIOX3P77I0svBwn2o38xkqUjDXYKERxlqdTsAOozTlgsM5ssljbeiUDvE8M7cTflSUkgKN76qLdBSFOEOQTyo&loadFrom=DocumentDeeplink&ts=175.29)):

I think that's a really important position to start with Barbara, because actually so many specialists seem to forget that 99.9% of the time, patients with COPD are in the community in primary care.

Barbara Yawn ([02:49](https://www.rev.com/transcript-editor/Edit?token=n4OWbreRUHH6YN8hxJDe4MTVZK-SjGS1RSBFIU9AL4c6rD4wXCs6G_4a2OaX2RpwESIZKf6FD-qgd__SOVcqExOZPmM&loadFrom=DocumentDeeplink&ts=190.57)):

Yes, that's true. And there's data from around the world that anywhere from 80 to, as you said, 99% of COPD care is given by primary care clinicians. So, we need to be part of the team and we need to have lots of information about how to best approach COPD.

Richard Russell ([03:13](https://www.rev.com/transcript-editor/Edit?token=KaK-Y9o6X2s2Py91BUH9y_sLxC3KxjE-wpkwlpLGPzdKfFJxh6kQyiRj0-dY6Kr9439BtoCjke3fGAOPOx11a5RKWRI&loadFrom=DocumentDeeplink&ts=153.02)):

Well, let's talk about something which has been difficult to define which is dyspnoea, breathlessness. Barbara, tell us a little bit about the impact of breathlessness in COPD.

Barbara Yawn ([03:21](https://www.rev.com/transcript-editor/Edit?token=zroFdLe0IAvd3L1rZQ6Z0bSxVTi433sOLbiqpUtl0LdxXAV-f2WjwP3zIPIHThCeMIEe8fNhxvgW-VqUMcvf49EVBNQ&loadFrom=DocumentDeeplink&ts=164.27)):

Well, you're absolutely right. It is difficult. We don't have some magic test for breathlessness. It is the patient's perception and patients are very interesting. They ignore it for many years. They will change their activities because they're short of breath and they just quit doing something. Then they don't feel short of breath. I think that it's one of the more difficult questions for us to get at as primary care. We need to ask the right questions and figure out what's going on. For example, I like to use a couple of things. One is just a one question from the MMRC, which is the Modified Medical Research Council dyspnoea questionnaire, and level two is the cut-off, I think, for severe impact. That's when somebody says they can't keep up with other people their own age, they have to walk slower, and they have to stop frequently for shortness of breath.

Barbara Yawn ([04:24](https://www.rev.com/transcript-editor/Edit?token=cKGOFYZEnmyD6jnjfI1uf54sk8_YRu4w7WQqEPewOuLIS3V1G5ygUqsvs0gYUT6gzWfKImJIO2RxEAllKMeLk0_FWxI&loadFrom=DocumentDeeplink&ts=231.4)):

So, this is a pretty quick question to ask someone, and if they say, "Oh, no, I'm fine." Then we can go from there. But if they say yes, then we can ask a little bit more. The other thing that I've found that's real important is saying, "Could you give me a thumbnail sketch of what your day's like." Let me give you an example. I had an older gentleman who said, "Oh, no, I can do all my usual activities, no problem at all with shortness of breath." Then I said, "Tell me about your typical day." What he said was, "I get up in the morning, it takes me a couple of hours to get dressed and eat breakfast because I get short of breath while I'm doing all that, and then after that, I'm so tired I just go sit in my lounge chair and watch TV all day."

Barbara Yawn ([05:12](https://www.rev.com/transcript-editor/Edit?token=1D29461n8OIAtuLGR3yE2vYzcl5okU7HJK0xy4Qvfq4zzt64Mrwfqq1cNpRkhyNweLIdGX3eEqoODZE6Oq-JOloVLo0&loadFrom=DocumentDeeplink&ts=280.45)):

Here's this man who said, "Oh, no, I do all my usual activities," which was clicking the remote. But if I hadn't asked him more details, I would've missed that his life has really changed because of his COPD and his dyspnoea. The other group of people that are helpful, I think if they come with the patient or if you do a tele-visit, it's the family. Because sometimes the person with COPD is depressed and they've just given up, but the family can be really helpful and say, "Well, he or she can't play with the grandchildren anymore. She or he loves to cook, and they can't stand up and walk around the kitchen even to cook something simple." So, the family can be, I think, really helpful in telling you what's going on.

Richard Russell ([06:08](https://www.rev.com/transcript-editor/Edit?token=nM3sJPCwTPJevNEbNWgXRZGyNgsVp0FsrWGsPDSVplUevSM0uU7WsU8yL3FrmDFhq19iTzIB4VH2kA4V7w6H1qe8or8&loadFrom=DocumentDeeplink&ts=296.08)):

This is often very hidden. Let's also just quickly at the beginning address the fact that actually, we do now have treatments for breathlessness and our guidance actually says we need to consider breathlessness significantly and seriously.

Barbara Yawn ([06:20](https://www.rev.com/transcript-editor/Edit?token=-4rHeR6_mIhaE6dEe7DfttTaVrPCylEy05DpyBc9lJUwTLizBujxyxEVSu4S0AjOK0Y7lxRp777w67lDAy-Mjhy93Vw&loadFrom=DocumentDeeplink&ts=308.38)):

Oh, absolutely. 40 years ago, plus when I started practice, we just didn't really have much for COPD at all. It was just a death sentence. But now we do have excellent treatments and the GOLD recommendations that most people know about, or the ATS, American Thoracic Society or the European Respiratory Society do have recommendations. And all of them really do start with pharmacotherapy after you make the diagnosis, of course. And we do have excellent bronchodilators, and they are designed specifically for dyspnoea. As you know, there's two classes. The long-acting antimuscarinics or the LAMAS or the long-acting beta agonists, the LABAs. These work really quite well when used appropriately in our patients. Most of the recommendations, if you look, will say you can start with one and they recommend LAMA, if you're going to only use one. But they do point out that by the time most of us make the diagnosis in our practice, the patients are quite dyspnoeic. Most of my patients, I start on dual bronchodilator therapy with a LAMA plus a LABA in one inhaler now.

Richard Russell ([07:43](https://www.rev.com/transcript-editor/Edit?token=wg_fVNgKPycnSbJ6XS1NmN97req3ZJbWYZbCX52hiW0OH8vPpDwz-xdPqVY-fFBvHWTb6FBAMu4HA6uF4uRPOmbaOFk&loadFrom=DocumentDeeplink&ts=393.28)):

We've got some treatments and we'll come back to that in a second, but let's come back to the patient. You've got a patient who's saying they're breathless. Is there a way we can pick it up even earlier to prevent this downward spiral? Because so often, as you've also mentioned, people have adapted their lifestyle to working around their breathless and we are missing the boat, aren't we, because it's sometimes very late.

Barbara Yawn ([08:05](https://www.rev.com/transcript-editor/Edit?token=TxkJJZ1hy_9-cAviNSPkMsSao0MylPLragEGd_Ovv-XXXRSU6YZUmprOEUTreLUvHuY8IzzgmKw0R3e3TofirA0dkNg&loadFrom=DocumentDeeplink&ts=416.15)):

It is frequently very late. I do think that what we need to think about is, is this person someone who has risk factors for COPD? Have they been a long-term smoker? Have they been in an occupation or been around tobacco smoke? And then if any of those are true, we need to ask at the right questions, which isn't just, "Are you doing all your usual activities?" It is trying to get beyond that and saying, "Is there something that you can't do now because of breathlessness that you could do three years ago, five years ago, or even six months ago." I think we need to do that. Right now, we don't yet have a perfected screening tool for COPD. But I think that is a good question to figure out, is just ask them about their activities and changes.

Richard Russell ([08:57](https://www.rev.com/transcript-editor/Edit?token=oJo4b33rDvFVBvezlAyz1NtQQF4HeSWBd4Xl2XS-RnKVbdjcTmSABr1Mzv592hJNWTS6kwmVSHSYe7p0nKasbYY2-tM&loadFrom=DocumentDeeplink&ts=470.79)):

I think that's really, really critical. I think challenging and having a zero tolerance for breathless and saying what has changed for you. I agree absolutely. I think that's a fantastic way of putting it, and it actually really works as well, which I do agree. Barbara, breathlessness is complex and treating it is also complex. Are there treatments other than medications that we need to focus on sometimes for breathlessness?

Barbara Yawn ([09:22](https://www.rev.com/transcript-editor/Edit?token=FoqRQGzmiPu82D_oRtjasnI9ilICttdcRGIClNHqACrUbuQpBFy22qsncx8ME0Nafjuc2o6kwXlNOj4A3EYH4FnK7ys&loadFrom=DocumentDeeplink&ts=497.36)):

Absolutely. I think it's the whole package that we need to think about. We want the pharmacotherapy to work as best it can, and so to add to the pharmacotherapy, I think we do things like thinking about the other aspects. Like the muscles. The respiratory muscles, for example, are part of dyspnoea. If you have stronger respiratory muscles, you will have less dyspnoea, and so we teach people about diaphragmatic breathing. We teach them about pursed lip breathing. We teach them that if you do more activities, you will be able to continue to do more activities. One of the things that I do recommend for people is, if you are a little short of breath while you're walking, it's okay, keep walking.

Barbara Yawn ([10:12](https://www.rev.com/transcript-editor/Edit?token=fRG3bTKl8T4XJQjNNxRFN8zfMDWQ6TCWtODrh3KWpZzsOCYpVThXc6me3RSbYAbxJA16FYgcFSO_WIPHqGtE-aA9Flw&loadFrom=DocumentDeeplink&ts=547.7)):

It's not like chest pain where you get a little chest pain you're supposed to stop right away. It's okay to be a little breathless and keep walking and pushing your limits. That's how you're going to be able to do more. Then of course, there's the things of feeling panicked and depressed that we need to deal with instead of just ignoring them. How do you help a person who is short of breath? Stop, slow down, try to take those slower breaths in and out the pursed lip breathing kind of thing.

Richard Russell ([10:49](https://www.rev.com/transcript-editor/Edit?token=AEuEH-xYwVYs_vDt68zSxM0ynax7GYZS8a3J60Mvt0tvyTZLLHQgBxw3Cju2CxvPls0a3ym_o4PK5Bc6c75eFtzEV7k&loadFrom=DocumentDeeplink&ts=583.14)):

So sometimes I think we as chest physicians and as primary care physicians have been guilty of underplaying the importance of breathlessness, Barbara as well. "It's just a bit of breathlessness. Get fit, you'll get better." But there is evidence isn't there that actually breathless does impact on progression of COPD and mortality and on morbidity.

Barbara Yawn ([11:06](https://www.rev.com/transcript-editor/Edit?token=OT9Ili4vISLZCbidZcoBuf9nZVekCiHG2hsRzKqI647KGauUw5aR87y-6Ie1-R3cGxmzq80Yjct1e3miXizupZ_-1GI&loadFrom=DocumentDeeplink&ts=601.11)):

Absolutely. You talked about the spiral and I think that it is truly a spiral. People who have more dyspnoea or breathlessness are at greater risk for, as you said, poor quality of life, but also hospitalisation, exacerbations, mortality. All of those things are increased as the level of dyspnoea increases.

Richard Russell ([11:35](https://www.rev.com/transcript-editor/Edit?token=FQzdhWCvAY1M7gFDw8IfYaiXQmpiBTOxBZSLtXbl-zyasx7037jRjOpr-ePmMUKcR7GIeL1zdnG58T5iUXMQ4AaUybM&loadFrom=DocumentDeeplink&ts=629.68)):

Let's come back to treatments now and let's talk about how we should target pharmacotherapy at breathlessness. You've mentioned the role of single bronchodilators and dual bronchodilators and also inhalers. Would you like to unpack that a little bit more?

Barbara Yawn ([11:47](https://www.rev.com/transcript-editor/Edit?token=sxB2IMn87WYyZP7bhXAlw1VWd77b_prBF3JTsQL7q8CQ49TUyHd_TgVAXDfrLabcAfFaOTmsjte5JIj75ihhoqjL7O0&loadFrom=DocumentDeeplink&ts=642.42)):

Sure. I think that it is more than just choosing the drug. That is crucial that you choose the drug. As I said, I usually choose the dual bronchodilators. But we need to go on beyond that and think about devices. For example, there was just a study published not very long ago that showed that using the same drug, but in a Soft Mist Inhaler versus a dry powder inhaler, for example. With the soft mist, it decreased the rate of exacerbations and readmissions to the hospital. I think we have to think about those things. A person who has arthritis probably can't push the MDI button, and so that's not going to work for them. Someone who's just had an exacerbation may not have the inspiratory capacity to suck in that medicine from a dry powder inhaler. The Soft Mist Inhaler doesn't require the same level of coordination because it's a longer flow with the mist. So, it may actually provide some help beyond what you expect to get just from your molecules.

Barbara Yawn ([13:10](https://www.rev.com/transcript-editor/Edit?token=xVCMGL7f8wqoO-sFui3oyZNpbeVWMtGDiOhil9JYwr6tOAFRSSVU-cuFWaGVs1pyAyN9oefcb1jhlgq1VXXMG0NNqmM&loadFrom=DocumentDeeplink&ts=703.1)):

Going beyond just the drug is important and thinking about the device. Then, of course, you have to think about whether or not you taught them how to use the device inhaler. Technique, education, and observation is crucial, and of course, adherence. Can they afford their medicine? Are they using it daily? I have some patients, they say, "Well, it was too expensive, so I only use it every third day." Well, it's, it's not going to work very well that way. What can we do? But if I don't ask them those questions, I don't know.

Richard Russell ([13:50](https://www.rev.com/transcript-editor/Edit?token=YafzAgYOij2mPhi_QXxFRSsqz_BhA0ZStAKAZjQSgVYc-MoL95dGqON6MMosc6gohVrQVwVTLvtJcWO7-KzeV7lhCy8&loadFrom=DocumentDeeplink&ts=741)):

Yeah. I think it's really critical that we actually ask the right questions and get that absolutely right. Barbara, talking about treatments again, let me bring up the issue of inhaled corticosteroids. Do they have a role in treating breathlessness?

Barbara Yawn ([14:00](https://www.rev.com/transcript-editor/Edit?token=6CMygs7jcSIMDmpAqx8mReIplu2m_91xlTOXKScVQcSCoj06rci7erZsMqZ1-iO3LycR4iUcibwZ5Ef86mhNFDhK4yw&loadFrom=DocumentDeeplink&ts=753.54)):

They don't have a role in treating dyspnoea. That is not what the indication for inhaled corticosteroids or ICS is. If you go look at the GOLD recommendations, for example, they have an algorithm or a flow sheet for dyspnoea, and ICS is not part of that. That is on the other side for exacerbations. If I have someone that's having problems with dyspnoea, I go on to the dual bronchodilator therapy, and then I'm going to think about pulmonary rehabilitation. I'm going to think about other things around it that I can do. Now if they start having exacerbations and they're on the dual bronchodilator therapy, and they're having two or more exacerbations a year, and especially if they end up in the hospital, then it's time to think about ICS. But even that now is not just automatic because now we have the treatable traits, and one of those is blood eosinophils. People who have low blood eosinophils are not nearly as able to use or have the same kind of prevention from exacerbations with ICS, as people with higher blood eosinophils. It isn't just an automatic knee jerk, "Let's just add ICS." We have to think about why.

Richard Russell ([15:26](https://www.rev.com/transcript-editor/Edit?token=GM7K2CNRAS-XjD8H6jiNq3rFRXzyEr9xA2JgOqmNHEz9b7RnGoHRkqxV0fR3QCe8MgA-U4Ecd0j1zfD0o2Jg6Ilc5PU&loadFrom=DocumentDeeplink&ts=844.66)):

So just to summarise that little section from a clarity point of view, where possible we should give dual bronchodilators to optimise the bronchodilatation, to deal with breathlessness, and reserve inhaled corticosteroids for those people having exacerbations, per the guidelines, right?

Barbara Yawn ([15:42](https://www.rev.com/transcript-editor/Edit?token=8p-YeNKs8emV5TD7lpMRplN77X86hjdsTrcZoSLHi2HKKFKx9mbXa35Vwcme3gQJdm4YHoX7tJ7IyDk_i0z383Yqw_c&loadFrom=DocumentDeeplink&ts=857.47)):

Correct.

Richard Russell ([15:43](https://www.rev.com/transcript-editor/Edit?token=GW56jSG8m4VgJ9dWXfoNUr9J-uHKAEi6bAZS1qULNbwb2Rp_SXoV1TnpPiFiwQ14tPTaxHjKsHxqhOFbSvaB6FrseBw&loadFrom=DocumentDeeplink&ts=858.13)):

Excellent. In just a minute, Barbara, I'm going to ask you to summarise this discussion and give us your key tips for better practice and management of breathlessness. In a moment, I'm also going to talk about this paper which I believe is really important, ‘The Impact of Lung Function and Exacerbations on Health-Related Quality of Life in COPD.’ So, Barbara, can you give us your three or four absolutely key critical points for practice?

Barbara Yawn ([16:08](https://www.rev.com/transcript-editor/Edit?token=98r8hKU_2sEgyVYsBySGLgMVwsPpKyizYhQj6N6TgCUlgnpnZjjZBARy6L3H6sOlVkoAzeO00KFaBfnk0YcvrfA2rH4&loadFrom=DocumentDeeplink&ts=882.6)):

Yes. When you're thinking about COPD, the primary symptom you're going to think about is dyspnoea, and you need to be able to figure out what level of dyspnoea your patient has. I really like using, as I said, the one question, “tell me a thumbnail sketch of your life” to figure out the impact of that dyspnoea on all aspects. Then of course, as I approach therapy, I am going to start almost all my patients on dual bronchodilator therapy to get the synergy of these two. I need then to think about the device, I need to think about inhaler education, and I need to think about adherence. Then finally, because we have the whole patient there in front of us, we need to think about all the comorbidities, and how treating them is going to make all of our other therapy better. One of the therapies I really like is pulmonary rehab. I think that it helps patients learn about why they take their medicine, how to take their medicine, how to exercise all of those things packaged together. For those of us in primary care, it really is helpful because I don't always have time to do everything I'd like to.

Richard Russell ([17:29](https://www.rev.com/transcript-editor/Edit?token=P7gbcLuEcSaosA_55nPEtkzOtl-OPZoRRyCzOIREsjscT2RuWOfWmHQk-ghBNpOfOMi6f3q_3q6DHI2CMZ0tZP_0HhM&loadFrom=DocumentDeeplink&ts=965.41)):

Dr. Barbara Yawn, thank you for joining us today. The critical thing I've got from this is really to ask the questions. If we don't ask about breathlessness, we will never understand the impact on individual patients. Thank you for joining us today on the Medical Insider COPD podcast. It's been a great pleasure.

Barbara Yawn ([17:45](https://www.rev.com/transcript-editor/Edit?token=yPcUi6gSGto0gU9Xmm4z1hoV_kALE-1qg6N0Sl1Jskw_T2wq-V5t0U4N00T0Qao-PdTZlI0hntFVVY1AkjGDS-T1DUc&loadFrom=DocumentDeeplink&ts=980.62)):

Thank you. I've enjoyed it.

Richard Russell ([17:53](https://www.rev.com/transcript-editor/Edit?token=nD5-g6oOAseJdhC95uafTwmPfZ_PV_Fr3zUcPvsc7M3mtZgPWg7Qp8MFb97ul26UbIO5Uz3pIMLttK8614Q2bMZyRec&loadFrom=DocumentDeeplink&ts=0.55)):

I'm going to unpack for you now an important new publication entitled ‘Impact of Lung Function and Exacerbations on Health-Related Quality of Life in COPD Patients Over One Year, a Real-World Analysis.’ It's published in the *International Journal of COPD*, 21st of September, volume 16, page 2637 and following. It's by Alisa Stöber et al. from Germany.

Richard Russell ([18:15](https://www.rev.com/transcript-editor/Edit?token=VEU1qjr8mtiZ4iZU19pUrq41_N3mjcRJIkxbGGB1fY__NKMHlG5bfXD_LyGf4i3911di_qiDYd6FJEdzvJzrlcPRM0s&loadFrom=DocumentDeeplink&ts=26.54)):

The question here is how do exacerbations affect patients’ quality of life? There's a real lack of real-world data on this. Especially if you divide patients up into their GOLD groups to start with. So, this group followed over 3000 patients and analysed their quality of life, looking at CAT scores, visual analogue scores, and also Euro-QoL 5Ds. And they compared those who had exacerbations or not and also those who declined their lung function by more or less than 100 mL.

Richard Russell ([18:42](https://www.rev.com/transcript-editor/Edit?token=tnGkH-jJMej5b3nvR8p0jpEULrVYnuV1_6nQMbQJgmLGphcwc7GjOoUE2eSGtlSX4_2hzc2QGOZUC8GsoZjBQ7tJF28&loadFrom=DocumentDeeplink&ts=54.03)):

So, what did they find? They found that FEV1 decline had an impact on quality of life, but not reaching the minimal clinically important difference. CAT score change was 0.74. There was no change in the VAS. Exacerbations, particularly severe ones, hospitalisations, significantly impacted quality of life with a CAT score change of 1.58. This was especially prevalent in those who began in GOLD A and B. It was more likely if you were male, had a higher modified Medical Research Council score and at higher Charleston index, low body mass index and a low baseline FEV1.

Richard Russell ([19:18](https://www.rev.com/transcript-editor/Edit?token=WIPSAjpDF-ovHFiuM2oVJX7D0sM4Xjy8aDn941d-o32TbzNKLIVsUUDLWrt0HAJoDjl9cBja6v9AzYX5pMp-IndLMt0&loadFrom=DocumentDeeplink&ts=89.96)):

So how do we take this forward? Well, we need to recognise the risk of loss of quality of life is highest in those that start with the best baseline. We need to focus on risk assessment and also prevention and not forget those in GOLD A and B. So, we've got a great opportunity here for optimisation of therapy. And seeing as we've been talking about breathlessness and breathlessness impacts quality of life, optimising therapy as early as possible is clearly essential to reduce exacerbations.

Richard Russell ([19:53](https://www.rev.com/transcript-editor/Edit?token=isTmpkSmMMc4gSXdHIhkNZapgT8VGV5KFnJXDuayCOI4hh8uULQIGHfc2S4dlcqSoLi1PYT4MvjOGOJOdRHe7CAFiSQ&loadFrom=DocumentDeeplink&ts=0.4)):

Right now, I'm going to unpack for you something on social media which is a hot topic for our patients. That's the fact that winter's coming and they are wearing masks. Do they need to keep wearing masks? Patients are aware of this and concerned about it, but also may be seeing the positive side. There's a lot of chat now on Facebook, Twitter, and on the forums, such as in the COPD Foundation, about whether we need to wear masks this winter to protect us from viruses. The viruses usually cause exacerbations of COPD, and our patients know this and are keen to avoid them. However, they hate wearing masks and find this difficult.

Richard Russell ([20:29](https://www.rev.com/transcript-editor/Edit?token=hKJ_zsG3XUsNVui6rD4H8YgCLi9ujpsLQtTI95H0TfiV4cz87R8Pg_hkaDKSmj3bwYitssewcSdmURQ1T30pFdyWQWg&loadFrom=DocumentDeeplink&ts=38.35)):

Interestingly on the social media front, there's many people saying, "We need to do this because it's really protective of our lungs." And people agree. People on the positive side also like the fact they can customise and find the most comfortable masks for them. There's no doubt though that they understand the need for mask wearing and the fact that viruses, such as the respiratory syncytial virus and the influenza virus, are coming and we can be protected by appropriate social distancing, mask wearing, and hand washing. So, this is on the chat out there in social media. What do we need to tell our patients to encourage them in the benefits of appropriate mask wearing, social distancing, and hand washing to prevent transmissible respiratory viruses causing exacerbations? This will help them and help us.

Richard Russell ([21:14](https://www.rev.com/transcript-editor/Edit?token=VQkLMgfrtXAx883hmiAHF6RkGQZl3jwseICBMN02KvBXB3wJ39ni4_4MJNmUepTJMzIEdXvlIJTSsI42UcjbROoQQfE&loadFrom=DocumentDeeplink&ts=83.26)):

I hope you've enjoyed today's Medical Insider COPD Podcast. We've looked at dyspnoea, breathlessness, the impact of this on patients, and the need to actually focus on asking our patients the right questions and then treating with optimal therapy as early as possible to prevent decline and to prevent COPD impacting their quality of lives. I hope you'll join me on the next episode of Medical Insider COPD Podcast when we unpack new and important data in COPD, look at another important new paper, and what's also hot in social media. Thank you for joining me today and remember, subscribe to Medical Insider COPD Podcast.