later.[523,525,527]

These considerations have several relevant implications for the management of ECOPD:

1) The current GOLD recommendations emphasize the importance of an appropriate *differential* diagnosis of ECOPD from other conditions that may mimic/aggravate them (e.g., heart failure).[528] Yet, if they do exist, they need to be treated appropriately.

2) It may be advisable to measure *routinely during* ECOPD markers of CVD, such as troponin and brain-natriuretic peptides.[522,523] The evidence supporting this proposal is still weak, but the observations discussed above support it.[525,526] If any of these markers are abnormal *during* the episode of ECOPD, appropriate further investigations and treatment are required following CVD recommendations.

3) Currently, there is no evidence to support the routine use of *preventive* cardiovascular treatment (e.g., aspirin) *during* or *following* an episode of ECOPD, but this again merits research. Similarly, β-blockers and statins need to be prescribed following their CV indications although these drugs did not show any benefit in clinically stable patients with COPD without CV indications. Importantly, COPD patients should not be denied β-blocker use if there is a CV indication.

4) Finally, although preventing ECOPD is already a main goal of COPD treatment because of their impact on the prognosis, lung function and health status of the patient,[519] the increased cardiovascular risk that occurs during and following the acute episode is another strong clinical argument to prevent these acute episodes, as discussed in detail in **Chapter 4**.

Combined initial COPD assessment

In 2011, GOLD proposed to move from a simple spirometric grading system for disease severity assessment and treatment to a combined assessment strategy based on the level of symptoms (mMRC or CAT™), the severity of airflow obstruction (GOLD grades 1-4), and the frequency of previous exacerbations. This classification was proposed to guide initial pharmacological treatment. The main step forward achieved by this combined assessment strategy was to incorporate patient-reported outcomes and highlight the importance of exacerbation prevention in the management of COPD. The initial version of the combined assessment relied on both the severity of airflow obstruction (GOLD grades 1-4) and the frequency of previous exacerbations to assess exacerbation risk.

The severity of airflow obstruction was subsequently removed from this combined assessment scheme considering its lower precision at the individual level (versus that at a population level) to predict outcomes and drive treatment decisions, while complexifying the use of the classification by clinicians.[468,490,529,530]

In the 2023 GOLD report, GOLD proposed a further evolution of the ABCD combined assessment tool that recognized the clinical relevance of exacerbations, independently of the level of symptoms of the patient. **Figure 2.11** presents this proposal. The A and B groups remained unchanged, but the C and D groups were merged into a single group termed “E” to highlight the clinical relevance of exacerbations. It was acknowledged that this proposal would have to be validated by appropriate clinical research.