

Inhaled Corticosteroids	- Regular treatment with ICS increases the risk of pneumonia especially in those with severe disease (Evidence A) - An ICS combined with a LABA is more effective than the individual components in improving lung function and health status and reducing exacerbations in patients with exacerbations and moderate to very severe COPD (Evidence A) - We do not encourage the use of a LABA+ICS combination in COPD. If there is an indication for an ICS the combination LABA+LAMA+ICS has been shown to be superior to LABA+ICS and is therefore the preferred choice - Triple inhaled therapy of LABA+LAMA+ICS improves lung function, symptoms and health status, and reduces exacerbations, compared to LABA+ICS, LABA+LAMA or LAMA monotherapy (Evidence A). Recent data suggest a beneficial effect of triple inhaled therapy versus fixed-dose LABA+LAMA combinations on mortality in symptomatic COPD patients with a history of frequent and/or severe exacerbations - If patients with COPD have features of asthma, treatment should always contain an ICS - Independent of ICS use, there is evidence that a blood eosinophil count < 2% increases the risk of pneumonia (Evidence C) - Combinations can be given as single or multiple inhaler therapy. Single inhaler therapy may be more convenient and effective than multiple inhalers
Oral Glucocorticoids	Long-term use of oral glucocorticoids has numerous side effects (Evidence A) with no evidence of benefits (Evidence C)
PDE Inhibitors	- In patients with chronic bronchitis, severe to very severe COPD and a history of exacerbations: - Roflumilast improves lung function and reduces moderate and severe exacerbations (Evidence A) - Ensifentrine improves lung function (Evidence A) but an effect on exacerbations has not been evaluated in patients at increased exacerbation risk
Antibiotics	- Long-term azithromycin and erythromycin therapy reduces exacerbations over one year (Evidence A) - Preferentially, but not only in former smokers with exacerbations despite appropriate therapy, azithromycin can be considered (Evidence B) - Treatment with azithromycin is associated with an increased incidence of bacterial resistance (Evidence A) and hearing test impairments (Evidence B)
Mucoregulators & Antioxidant Agents	- Regular treatment with mucolytics such as erdosteine, carbocysteine and NAC reduces the risk of exacerbations in select populations (Evidence B) - Antioxidant mucolytics are recommended only in selected patients (Evidence A)
Biologics	- In patients with moderate to severe COPD with a history of exacerbations, chronic bronchitis and higher blood eosinophil counts (≥ 300 cells/μL): - Dupilumab reduces exacerbations, improves lung function and quality of life (Evidence A)
Other Anti-Inflammatory Agents	- Statin therapy is not recommended for prevention of exacerbations (Evidence A) - Simvastatin does not prevent exacerbations in COPD patients at increased risk of exacerbations and without indications for statin therapy (Evidence A). However, observational studies suggest that statins may have positive effects on some outcomes in patients with COPD who receive them for cardiovascular and metabolic indications (Evidence C) - Leukotriene modifiers have not been tested adequately in COPD patients