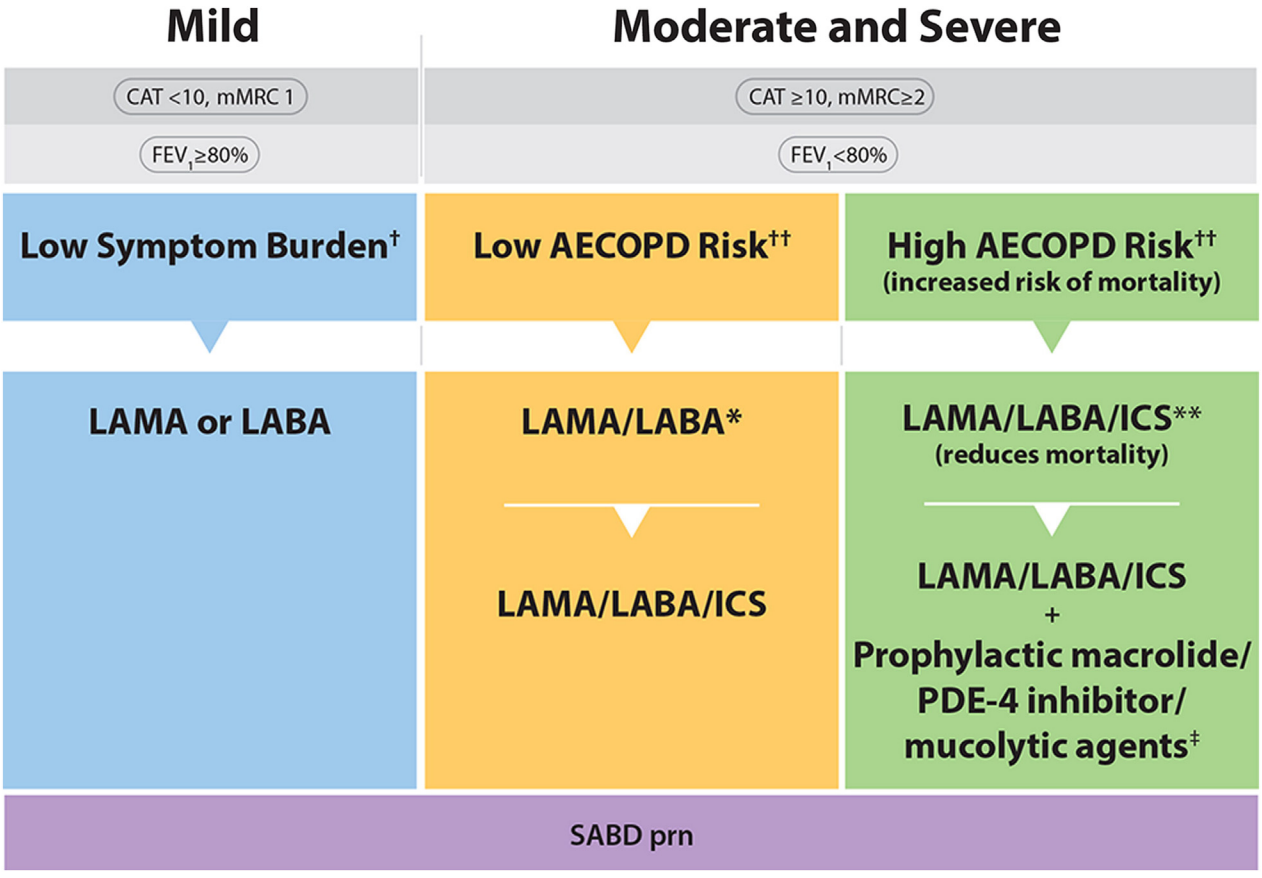

Figure 3 – *COPD pharmacotherapy. This figure promotes an evidence-informed approach that aligns proven effective treatments with spirometry, symptom burden, risk of future exacerbations, and mortality risk. Because of the clinical heterogeneity in COPD, spirometry should not be used in isolation to assess disease severity and this is why it is also important to perform a thorough clinical evaluation of the patient, including symptom burden and risk of exacerbations that permits the implementation of treatments that are specific for subpopulations. SABD prn (as needed) should accompany all recommended therapies across the spectrum of COPD.†Symptom burden encompasses shortness of breath, activity limitation, and impaired health status.††Individuals are considered at "Low Risk of AECOPD" if ≤ 1 moderate AECOPD in the last year (moderate AECOPD is an event with prescribed antibiotic and/or oral corticosteroids)* and *did not require hospital admission/ED visit. Individuals are considered at "High Risk of AECOPD" if ≥ 2 moderate AECOPD* or *≥ 1 severe exacerbation in the last year (severe AECOPD is an event requiring hospitalization or ED visit).*LAMA/LABA single inhaled dual therapy is preferred over ICS/LABA inhaled combination therapy considering the additional improvements in lung function and the lower rates of adverse events such as pneumonia. ICS/LABA combination therapy should be used in individuals with concomitant asthma. There is no universally accepted definition of concomitant asthma. The 2017 CTS Position Statement on COPD Pharmacotherapy provides guidance on the assessment of patients who may have concomitant asthma.**Triple inhaled ICS/LAMA/LABA combination therapy should preferably be administered in a single inhaler triple therapy (SITT), and not in multiple inhalers (see text), although we acknowledge that some patients continue to prefer separate inhalers. ‡Oral pharmacotherapies in this group include prophylactic macrolide, and PDE-4 inhibitor and mucolytic agents for patients with chronic bronchitis. AECOPD, acute exacerbation of COPD; CAT, COPD assessment test; ICS, inhaled corticosteroid; LABA, long-acting ß2-agonist; LAMA, long-acting muscarinic antagonist; mMRC, Modified Medical Research Council; SABD prn, short-acting bronchodilator as needed.*

Informing the Pathway of COPD Treatment (IMPACT),[42,43] performed in symptomatic individuals with COPD at a high risk of future exacerbations, have provided strong evidence for an improvement in dyspnea with LAMA/LABA/ICS triple combination therapy compared to either LAMA/LABA dual therapy or ICS/LABA combination therapy, leading to strong recommendations, accordingly (**rec. PICO P.1.C.**). Of note, we extrapolated this to a population at low risk of exacerbations but with likely a similar symptom burden.

Health Status: Health status is often impaired in individuals with COPD and relates to impaired lung function, high psychological and physical symptom burden, low physical activity levels, frequent exacerbations, and comorbidities.[44,45] Health status may be improved in COPD through both pharmacological and nonpharmacological (eg, pulmonary rehabilitation) interventions. A simple, validated tool such as CAT can be used clinically to routinely assess health status[46]; whereas, other reliable and validated disease-specific health status