

An Editorial Note on Chronic Obstructive Pulmonary Disease (COPD) in Human

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Editorial

Chronic Obstructive Pulmonary disease or COPD is increasingly becoming recognised as a systemic illness. The hormonal, metabolic, and musculoskeletal consequences of oxidative stress, inflammatory mediators, cytokines, and endocrine hormones have just recently been discovered. The epidemiology of inflammatory markers in patients with chronic obstructive pulmonary disease has only been studied in a few researches. Skeletal muscular weakness, atrophy, and osteoporosis are common extra pulmonary consequences of chronic obstructive pulmonary disease. Only a few studies have established the parameters in an epidemiological framework, and the consequences of systemic inflammation can be quantified at specific extra pulmonary organs such as skeletal muscle or in more general terms using body composition, body weight, or derived measurements.

Nonetheless, these studies show a link between inflammatory markers and forced expiratory volume in one second, and not just in people who have severe chronic obstructive pulmonary disease. In addition, it is becoming obvious that systemic indicators in chronic obstructive pulmonary disease have significant prognostic implications. Millions of people worldwide suffer from chronic obstructive pulmonary disease (COPD), which causes morbidity, mortality, and a significant drain on health-care resources. The epidemiology of COPD, management methods, and the health and economic effects of this ailment in North Carolina are all included in this paper. Chronic obstructive pulmonary disease (COPD) is a lung illness caused by smoking that has a high death and morbidity rate. It places a huge financial strain on the health-care system. This has a profound social impact on those who are impacted and their families. COPD in general, critical care therapy of patients presenting with an acute exacerbation of COPD, and preventative approaches are discussed in this article.

COPD is a leading cause of death in the United States and around the world. The most frequent risk factor for the development of COPD is cigarette smoking. The disease progresses differently in different patients, with some

having a high degree of blockage and few symptoms, while others with better lung function have a higher symptom burden. Pharmacologic therapy aims to alleviate symptoms, enhance exercise tolerance, and lower the risk of aggravation. There has been no evidence that pharmacologic therapy improves COPD survival. Patients with COPD who have symptoms despite first-line inhaled medication, have frequent exacerbations, have been hospitalised, or have moderate-to-severe disease should see a pulmonologist. Chronic obstructive pulmonary disease (COPD) is a lung illness caused by smoking that has a high death and morbidity rate. It places a huge financial strain on the health-care system. This has a profound social impact on those who are impacted and their families.

In this note, we look at COPD in general, critical care management of COPD patients with acute exacerbations, and preventative approaches. Every year, more than 3 million individuals die from chronic obstructive pulmonary disease (COPD). Despite breakthroughs in the treatment of symptoms and the avoidance of acute exacerbations, little progress has been made in slowing the development of the disease or lowering mortality. It is necessary to gain a better knowledge of the complicated disease pathways that lead to COPD. Smoking cessation programmes, increased physical activity, and early detection and treatment of comorbidities are all important factors in lowering disease burden.

COPD will remain a serious health-care concern for decades unless a global political and economic effort is made to minimise tobacco smoking, regulate environmental exposure, and find alternatives to the large usage of biomass fuel. Consistent respiratory symptoms and worsening airflow obstruction characterise chronic obstructive pulmonary disease (COPD). Tobacco usage is the most common cause, but it is not the only one. COPD is diagnosed when the FEV1-FVC ratio after bronchodilators is less than 0.70. Inhaler therapy is the cornerstone of treatment, but it should be supplemented by a multifaceted management strategy that includes smoking cessation counselling and pharmacotherapy, pulmonary rehabilitation, comorbidity treatment, influenza and pneumococcal immunizations, and the prescription of long-term oxygen therapy in hypoxemic patients.

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