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Updates in the Management of COPD based on the GOLD Guidelines

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Chronic Obstructive Pulmonary Disease (COPD) is a common respiratory condition, accounting for 5% of deaths globally.[1] It is characterized by cough, dyspnea, and airflow limitation. Common risk factors include smoking, fume and dust exposure, and pulmonary or systemic infections.[1] Chronic morbidity and mortality are associated with COPD. People with COPD can have frequent office visits and hospitalization from exacerbations, and require chronic pharmacologic therapy, which results in high utilization of healthcare resources.

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) committee published updated guidance with recommendations for the diagnosis, management, and prevention of COPD in early 2026.[1] The GOLD report is updated based on new evidence identified during a standard review process that occurs twice a year compared to a single systematic review of each topic.

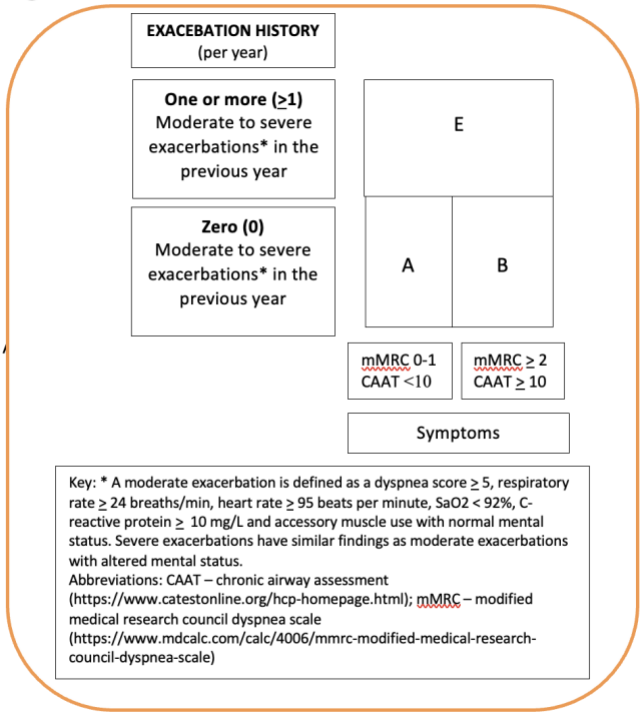
This newsletter reviews new evidence presented in the 2026 GOLD Report. Recommendations for the management of COPD is presented and the Oregon Health Plan (OHP) Fee-For-Service (FFS) policy for inhalers used in the management of COPD is summarized.

GOLD Updates

Important updates related to COPD management and pharmacotherapy include new definitions of GOLD A, B and E categories, revised management cycle and treatment algorithm to emphasize the distinction between initial pharmacotherapy and follow-up treatment, use of biologic therapy, and management of COPD exacerbations.[1]

One clarification made in the 2026 recommendations are to the GOLD ABE Assessment Tool.[1] Categories C and D have been combined into category E. The categories were adjusted to emphasize the importance that moderate to severe exacerbations play in predicting subsequent events. If exacerbations are more frequent or severe, the risk of additional exacerbations is even higher.[1] The threshold has been reduced so that even one moderate exacerbation may be cause for treatment escalation. Additionally, combination therapy may be appropriate as initial therapy in some patient with exacerbations (**Figure 1).**[1] Additional pharmacological therapy recommendations in patients naïve to treatment are included in **Table 1**.[1]

Figure 1. GOLD ABE Assessment Tool[1]



Pharmacotherapy

Initial pharmacotherapy for COPD should be selected based on the severity of symptoms, exacerbation risk, adverse reactions, patient comorbidities, drug availability and cost and the patient's preference and ability to use drug delivery devices. Recommendations for initial pharmacotherapy are presented in **Table 1**.[1]

Table 1. Pharmacological Management for the Initial Treatment of COPD[1]

Group	Treatment	Notes
E	LABA + LAMA	Consider LABA + LAMA + ICS if blood eos ≥ 300 cells/µL
A	Bronchodilator (No specific treatment recommended)	Short or long-acting bronchodilators, but long-acting are preferred
B	LABA + LAMA	If combination therapy is not appropriate there is no preference between LABA or LAMA

Abbreviations: eos – eosinophils; ICS – inhaled corticosteroids; LABA – long-acting beta-agonist; LAMA – long-acting muscarinic antagonist.

Treatment recommendations for patients with COPD who experience dyspnea and exacerbations are based on types and severity of symptoms as outlined in **Table 2**.[1]

Table 2. COPD Inhaler Treatment for Dyspnea or Exacerbation[1]

Symptom	Treatment
Persistent dyspnea	LABA or LAMA or combination LABA + LAMA
One or more moderate or severe exacerbation	LABA or LAMA LABA + LAMA – if blood eos < 300 cells/µL **OR** LABA + LAMA + ICS – if blood eos ≥ 300 cells/µL
Ongoing symptoms and taking LABA + LAMA therapy	LABA + LAMA + ICS – if blood eos ≥ 100 cells/µL **OR** roflumilast or azithromycin if blood eos < 100 cells/µL
Ongoing symptoms and taking LABA + LAMA + ICS therapy	roflumilast **OR** azithromycin
Ongoing symptoms and taking LABA + LAMA + ICS therapy AND Two moderate or one severe exacerbation AND blood eos ≥ 300 cells/µL	Biologic Therapy • Dupilumab (with chronic bronchitis) • Mepolizumab (with or without chronic bronchitis)
LABA + ICS and no relevant exacerbation history	Consider changing to LABA + LAMA
LABA + ICS with no relevant exacerbation history and high symptoms	Consider LABA + LAMA + ICS
LABA + ICS and current exacerbations with blood eos < 100 cells/µL	Consider changing to LABA + LAMA
LABA + ICS and current exacerbations with blood eos ≥ 100 cells/µL	Consider escalating to LABA + LAMA + ICS
Abbreviations: eos = eosinophil count; ICS = inhaled corticosteroid; LABA = long-acting beta-agonist; LAMA = long-acting muscarinic antagonist.	

Management of COPD exacerbations are an important aspect of managing patients with COPD. Pharmacotherapy recommendations are[1]:

- Initiation of short -acting beta-agonists (SABAs) with or without short-acting anticholinergics as the initial bronchodilators to treat an acute exacerbation.
- Systemic corticosteroids for 5 days can be considered to improve lung function (e.g., forced expiratory volume in 1 second [FEV_1]), oxygenation, and shorten recovery time and hospitalization time.
- Antibiotics are recommended in patients with purulent sputum, prior positive sputum bacteria culture, or requiring mechanical ventilation (invasive or noninvasive). When given for 5 days they have been shown to shorten recovery time, reduce chance of relapse, reduce treatment failure, and shorten hospitalizations.

Non-pharmacotherapy Recommendations

Management of patients with COPD also include important non-pharmacological considerations. General principles outlined in the GOLD guidelines are the following[1]:

- Patients who smoke are strongly encouraged to quit and get connected with smoking cessation resources and medications to assist with quitting.
- Recommended vaccination includes COVID-19, influenza, pneumococcal, respiratory syncytial virus (RSV), tetanus, diphtheria, acellular pertussis vaccine (Tdap) and shingles
- Measures such as pulmonary rehabilitation, exercise training, and COPD education should be considered. These have been shown to improve exercise capacity and quality of life in patients with COPD
- Long-term oxygen therapy may improve survival in patients with severe resting chronic hypoxemia, but otherwise should not be prescribed for patients with stable COPD and those with resting or exercise-induced moderate desaturation
- Surgical or bronchoscopic interventions may be beneficial in select patients with advanced emphysema refractory to optimized medical care

OHP Fee-For-Service Policy Guidance

Preferred therapies for FFS members are based on effectiveness, safety and cost considerations. These are provided in **Figure 2.**

Figure 2: OHP FFS Preferred COPD Inhalers

- SAMA and SAMA combinations: Atrovent, ipratropium, ipratropium-albuterol and Combivent Respimat
- LABA: Serevent
- LAMA: Spiriva Respimat and Incruse Ellipta
- LABA + LAMA: Stiolto Respimat, Anoro Ellipta or umeclidinium-vilanterol

Conclusion

Managing patients with COPD involves careful selection of pharmacotherapy based on patients' symptoms. Patients with exacerbations may be candidates for combination treatment as initial therapy to prevent additional subsequent events. Incorporating non-pharmacotherapy recommendations may provide additional benefit to patients with COPD.

Peer Reviewer: Christopher Slatore, MD, MS, Professor, Division of Pulmonary and Critical Care Medicine, Oregon Health and Science University

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1. Global initiative for chronic obstructive lung disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease - 2026 Report. Available at: https://goldcopd.org/wp-content/uploads/2026/01/GOLD-REPORT-2026-v1.3-8Dec2025_WMV2.pdf. Accessed July 6, 2026.