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Educational questions

1. Which one of the following statements is true regarding COPD and its comorbidities?

❑ The prevalence of COPD and comorbidities is consistent among different, available epidemiological studies due to a common standard definition and metholodology. ❑ Most people with COPD ultimately die of chronic respiratory failure. ❑ Depression is very uncommon in people with COPD. ❑ Inhaled corticosteroids may increase the incidence of pneumonia, yet decrease the incidence of exacerbations.

2. A 60-year-old male presents to your outpatient clinic for evaluation and management of COPD. Which one of the following combinations of comorbidities is the most likely to predict mortality?

❑ Coronary artery disease and oesophageal cancer. ❑ Depression and hyperlipidaemia. ❑ Pulmonary hypertension and diabetes. ❑ Stroke and chronic renal failure.

3. Which one of the following statements is true?

❑ People with COPD have an increased incidence of lung cancer in excess of their smoking-related risk. ❑ Despite widespread belief, data from the ECLIPSE study did not identify the presence of gastro-oesophageal reflux disease as an independent predictor of frequent COPD exacerbations. ❑ The incidence of osteoporosis in COPD patients is comparable to controls. ❑ AV nodal re-entry tachycardia is the most common arrhythmia in the population with COPD.

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4. Which one of the following statements is false?
❑ In the PLATINO study, the estimated prevalence of COPD in those aged over 40 years was between 8–20%.❑ The presence of obstruction is supposed to be classified based on the post-bronchodilator lung function. ❑ The definition of COPD is now uniform across GOLD, the ATS and the ERS. ❑ The "fixed ratio" criterion for COPD is simple and accurately estimates COPD prevalence across all age groups.

5. Heart failure can be divided into heart failure with reduced ejection fraction (HF-REF), heart failure with preserved ejection fraction (HF-PEF), and right-sided heart failure (cor pulmonale). How often are these types present in patients with COPD? (Select one of the following.)
❑ HF-REF 20%, HF-PEF 30%, cor pulmonale 50%. ❑ HF-REF 45%, HF-PEF 45%, cor pulmonale 10%.
❑ HF-REF 30%, HF-PEF 50%, cor pulmonale 20%. ❑ HF-REF 49%, HF-PEF 50%, cor pulmonale 1%.

6. Which one of the following diagnostic tests typically has an independent diagnostic value for detecting heart failure in the presence of COPD, and not in those without COPD?
❑ A history of ischaemic disease. ❑ Obesity (BMI >30 $kg \cdot m^{-2}$). ❑ Abnormal apical impulse. ❑ Exclusionary cut-points for natriuretic peptides.

7. Which one of the following statements is true regarding spirometry in patients with heart failure?
❑ Both FEV_1 and FVC can both be decreased by about 20%. ❑ Results are similar in patients with and without signs of fluid retention. ❑ The results with spirometry are not affected by the presence of heart failure. ❑ Diagnosing COPD with spirometry is affected, but not the grading of severity of COPD.

8. Which one of the following statements is true? Drugs for heart failure can be used in patients with COPD:
❑ With the exception of beta-blockers. ❑ With the exception of digoxin. ❑ With no exceptions, when carefully uptitrated and dosed. ❑ With the exception of beta-blockers and digoxin.

9. Which one of the following statements is true? The best way to assess malnutrition in COPD is by:
❑ Measuring body weight. ❑ Calculating BMI. ❑ Assessing fat-free mass. ❑ Assessing fat mass.

10. Which one of the following is not a risk factor for the development of malnutrition in COPD?
❑ Hypoxia. ❑ Hyperactivity. ❑ Decreased food intake. ❑ Medication use.

11. Based on current knowledge, which one of the following is the best treatment for malnutrition in COPD:
❑ Nutritional supplementation. ❑ Exercise. ❑ A combination of nutritional supplementation and physical exercise. ❑ An increase in general food intake.

12. Malnutrition is detrimental to the prognosis in COPD. In the case of obesity, the effect on prognosis is less consistent. Which one of the following statements is true?
❑ Obesity is beneficial to prognosis in severe COPD. ❑ As in the healthy, obesity is detrimental to prognosis.
❑ The long-term effect of obesity in COPD is always beneficial.

13. Which of the following statements is true regarding the epidemiology of overlap syndrome?
❑ The prevalence of overlap syndrome is approximately 17% according to the National Health and Nutrition Examination Survey (NHANES III). ❑ The prevalence of OSAS is as common as 24% in males and 9% in females according to the Wisconsin cohort study. ❑ The prevalence of overlap syndrome is about 1% of the general adult population. ❑ The Wisconsin cohort study found that an AHI of ≥5 events per hour was three times more likely in never-smokers than current smokers.

14. Which one of the following is not a protective factor against OSAS in COPD?
❑ Low BMI. ❑ Reduced diaphragmatic efficiency due to lung hyperinflation. ❑ Diminished REM sleep. ❑ Medication: theophylline.

15. Which of the following responses is not a result of intermittent hypoxia associated with OSAS in contributing to cardiovascular diseases?
❑ Increased sympathetic nervous system. ❑ Systemic inflammation and oxidative stress. ❑ Downregulation of the transcription factor NF-κB pathway. ❑ Insulin dysregulation.

16. With regard to overlap syndrome, which one of the following statements is false?
❑ Daytime hypercapnia and nocturnal hypoxaemia lead to pulmonary hypertension. ❑ The severity of obstructive ventilatory impairment was inversely correlated with the severity of sleep disordered breathing. ❑ The inspiratory capacity to total lung capacity ratio correlates with sleep efficiency. ❑ Treatment with nasal CPAP can reduce the CT 90.

17. Which one of the following statements is true?
❑ COPD can increase depressive symptoms. ❑ COPD can increase anxiety. ❑ COPD can severely negatively affect the quality of life. ❑ All of the above.

18. Which one of the following statements is true? A high score on a mental health screening scale:
❑ Is diagnostic of a mental disorder. ❑ Should be ignored because of somatic overlap with ageing and COPD. ❑ Should be investigated by a clinician with mental health expertise and treated if appropriate. ❑ Is likely to be a false positive.

19. Which one of the following statements is false?
❑ Depression and anxiety are risk factors for initiating tobacco smoking. ❑ Smoking rates amongst those with severe mental illnesses are high. ❑ Failure of a tobacco-cessation attempt is not linked to having depressive symptoms. ❑ Smoking cessation itself may induce depressive symptoms in individuals with a history of depression.

20. When treating patients with COPD who also have depression, which one of the following statements is true?
❑ Cognitive behaviour therapy is indicated for those with severe depression. ❑ The safest and most effective pharmacotherapy is amitriptyline. ❑ There is level I evidence from COPD populations supporting the use of monoamine oxidase inhibitors. ❑ Selective serotonin re-uptake inhibitors are the preferred first-line therapies for controlling depression symptoms.

21. When treating patients with COPD who have an anxiety disorder, which one of the following statements is true?
❑ Low-intensity cognitive behaviour therapy-based interventions are recommended first-line treatment.
❑ Pulmonary rehabilitation has level II evidence for improving control of anxiety symptoms.
❑ Benzodiazepines are recommended first-line therapy to control panic disorder in COPD patients.
❑ Interpersonal therapy is contraindicated for social anxiety disorders.

22. Which one of the following statements is true?
❑ Anxiety symptoms should not influence the course or treatment of COPD. ❑ Depression is part of the normal clinical spectrum of COPD and requires no targeted treatment beyond the usual management of COPD. ❑ Because anxiety and depression are so common in COPD, cognitive behaviour therapy should be a core component of COPD management. ❑ People with COPD who also have clinical depression have worse health-related quality of life and more hospitalisations than those without comorbid depression.

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23. Regarding the treatment of mental health comorbidities in people with COPD, which one of the following statements is true?

❑ Anxiety symptoms are readily controlled by tricyclic antidepressants. ❑ Panic disorder usually responds to cognitive behaviour therapy. ❑ Chronic disease self-management programmes are more effective at reducing anxiety and depression symptoms in comparison with pulmonary rehabilitation. ❑ All patients demonstrating depressive symptoms should be referred to a psychiatrist or psychoanalyst.

24. How can skeletal muscle strength be best assessed in clinical practice? (Select one of the following.)

❑ It requires high-tech equipment and can hardly be performed in clinical practice. ❑ With a strain gauge and a maximal voluntary contraction. ❑ Using a magnetic or electrical twitch measurement as this avoids motivational bias which would otherwise make results unreliable. ❑ Ask the patient to perform a contraction against manual resistance, scored from 0 (no contraction) to 5 (normal contraction).

25. Which one of the following anabolic drugs could selected patients be currently advised to take to increase skeletal muscle strength?

❑ Testosterone. ❑ Erythropoietin. ❑ Myostatin inhibitors. ❑ Corticosteroids.

26. What is the best way to improve skeletal muscle function in a patient with COPD who is suffering from muscle weakness? (Select one of the following.)

❑ Optimal bronchodilator therapy and inhaled corticosteroids in case of exacerbations. ❑ Adherence to 30 min of physical activity (*e.g.* walking) per day on most days of the week. ❑ Pulmonary rehabilitation for at least 8 weeks. ❑ Nutritional therapy, including increased protein consumption.

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