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## Statins in COPD

### Selection Modalities and Mortalities



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#### To the Editor:

Cardiovascular disease contributes a significant share to the all-cause mortality of COPD<sup>1</sup>; therefore it is sensible to assume similar positive outcomes with its mortality benefiting measures in the COPD group as well. The study by Raymakers et al<sup>2</sup> published in *CHEST* (September 2017) found a significant all-cause and COPD-related mortality benefit with the use of statin drugs. The inclusion of a vast number of participants from databases, with a follow-up of a reasonable duration and a focus on adherence to statin drug use are the strengths of this retrospective study. Although the results endorsed a clear benefit with statin drugs, the rationale for certain selection methods and their potential bias cannot be overlooked. Contrary to the authors' quotation on the frequent existence of COPD among the population older than 30 years of age, they have included only individuals aged 50 years and older. A population with a mean age of 70 years might have a high prevalence of known or subclinical cardiovascular disease. Remarkably, documentation of this morbidity's existence in the studied COPD population was not attempted. It could have been more interesting to observe the statin drug-related mortality benefit among the subgroup of patients with COPD without known cardiovascular disease. Most importantly, identifying patients with COPD based on anticholinergic or beta-agonist use without spirometric confirmation might have allowed diagnostic inaccuracies and also ignored the significance of disease severity. The occurrence of such misdiagnosis without the support of spirometry

was recognized by a few earlier studies,<sup>3,4</sup> and for that reason the evidence-based guidelines<sup>5</sup> strongly recommend the objective measurement of airflow limitation for confirmation.

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## Response



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#### To the Editor:

We thank Sakhamuri and Chattu for their comments on our study.<sup>1</sup> The main criticisms raised in their letter were the following: (1) the age restriction for the cohort of patients with COPD clashes with the literature we cited; (2) the cohort was restricted to those without previous cardiovascular disease (CVD); and (3) the case definition for COPD was based on filled prescriptions for COPD-related, albeit not COPD-specific, medications. We appreciate these concerns and contend that they are largely limitations of administrative data and that we have appropriately identified and responded to these criticisms in our article (see the Discussion section); we do, however, address each point specifically here.

First, there were concerns that in the beginning of our paper we referred to a population of patients with COPD who were > 30 years of age whereas our study used an age criterion of 50 years of age or older. The