

lately high proportion of enrolled patients with chronic bronchitis or COPD as comorbid conditions (29%). However, the two diagnoses were not confirmed by performing bronchial reversibility testing with respect to a real-life design close to everyday clinical practice and possible additional workload for participating physicians. Generally, the proportion of patients with features of both asthma and chronic bronchitis/COPD is unclear and would have been influenced by the initial inclusion criteria used for the studies from which the data were drawn. In epidemiological studies, the reported prevalence rates for asthma-COPD overlap have ranged between 15% and 55%, with

variation by gender and age, and the wide range reflects the different criteria that have been used (2). Another cross-sectional observational study using a stepwise approach according to the GINA/GOLD guidelines identified only 9.2% of COPD patients as having asthma-COPD overlap (21). It is well known that asthma/COPD overlap syndrome is associated with a more severe course of the disease, lower related quality of life, and more frequent exacerbations (22).

Our study had several limitations. These included the real-life design and absence of a control group. In addition, a three-month follow-up does not provide a sufficient possi-

bility to monitor the maintenance of long-term asthma control and its impact on the frequency of flare-ups and other serious events as well.

Conclusion

In a majority of uncontrolled asthmatic patients, significant improvement of disease control represents an achievable goal thanks to an appropriate pharmacological strategy coupled with interventions aimed at a proper inhaler technique and adherence. Along with treatment of the underlying disease, it is important to pay close attention to comorbidities and smoking cessation.

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