



What is Important in Pulmonary Rehabilitation?

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Editorial

Since the Alma Ata convention, that health has had an important shift. Now it gives an emphasis to the system of the primary health care [1] with a different approach. It sees the individual as an integrated entity in an environment that is going to be affected by multiple factors; sociocultural, psychosocial genetic, which will help or stop any attempt to improve their health status.

From this point of view, multiple consensus, studies, and, norms have been carried out in Chile [2,3] to achieve the rehabilitation of patients with Chronic Obstructive Pulmonary Disease (COPD). All of them have been done through a program of chronic respiratory disease control in the care primary health care, called ERA Rooms (rooms of Adult Respiratory Diseases). This has as a fundamental support the control of asthma and COPD with evaluations and treatment of a multidisciplinary team (General practitioner, Nurse and Kinesiologists, who are trained in the control and treatment of diseases respiratory systems), emphasizing pulmonary rehabilitation in a group manner. Since 2005, local efforts have been made, as shown by Alex Campos [4] in his work, demonstrating that the results of his study are consistent with what is described in the literature and which demonstrate the significant benefits obtained with respiratory rehabilitation in patients with COPD. In addition, it is shown that in Chile a Respiratory Rehabilitation Program can be implemented in primary care using simple implements and with a low cost but despite these investigations and the creation of local consensus, it had very poor results. This happens due to poor adherence and problems in accessibility in terms of transport resources. This has put the programs in check, giving an important shift to the realization of rehabilitation, managing an individual rehabilitation in the controls, optimizing the patient's time and the latent resources within the Primary Care of Health (APS); this type of strategy has been detrimental to the volume of patients.

Since there the problematic starts, what therapy to carry out, in the last years there have been multiple investigations, generating much knowledge, prompting in the last year that the research lines be systematic reviews of the results, both individually and in groups, generating more controversy and giving a real emphasis to the physical activity of the patient with COPD. As well as Oluwasomi [5], who concluded that up to six months after Lung Rehabilitation the activity levels increase in people living with COPD which were associated with improvements in 6-minute Walk test), in Saint George's quality of life questionnaires Respiratory Questionnaire (SGRQ) and Chronic Respiratory Disease Questionnaire (CRDQ), slight improvements in FEV 1 and reduction of dyspnea. Despite all these benefits, no study reported hospital admission. Health professionals, social support, reduction of fear and viewing benefits (increased activity and reduction of dyspnea) mediated the associations reported but they were hampered by lack of social support, fear, comorbidities and

change in physical health. These factors reflect the issues surrounding public relations programs.

Other authors, such as Leandro Cruz [6], refer in their review that information is provided for researchers and clinicians through the identification and summary of the wide range of interventions to modify the levels of Physical Activity in patients with COPD. Unfortunately, it was not possible to carry out a formal meta-analysis of the results due to the heterogeneity of the data. In addition, the quality of the evidence is still very low, mainly due to the serious vagueness and inconsistency between studies, as well as the risk of bias, but it concludes that Physical Activity in patients with COPD is limited by symptoms (i.e., dyspnea, fatigue), but also by psychosocial/behavioral factors. Interestingly, the evaluation of physical activity training (with monitoring of the activity, for example with the use of a pedometer) is a very successful intervention to increase the daily activity levels of patients with COPD [7]. Another concept is the group or individual one, although we know that the effects will be beneficial, that idea is argued by Mendes [8] in their randomized study. In addition, Neves [9] in their meta-analysis summarizes that only three meta-analyzes involved three studies about the result of quality of life with the SGRQ questionnaire, two using the Borg scale and eight the 6MWT. The authors' results were similar to ours, which indicates that home or community pulmonary rehabilitation, compared to control groups, improves functional capacity, relieves dyspnea and improves quality of life in COPD.

On the one hand there is much benefit, on the other hand there are many elements that interfere in the realization of rehabilitation, as expressed by Cox [10], concerning that there are many factors, particularly those related to the environment, knowledge, attitudes and the behaviors, which interact to influence the derivation, acceptance, assistance and completion of pulmonary rehabilitation. Overcoming the challenges associated with the personal environment and/or the health system will be an imperative to improve access and acceptance of pulmonary rehabilitation, making it clear that despite the basic of the exercises carried out to benefit the health of COPD patients, society influences the progress of these.

The sight is set on this disease. There is no doubt about the benefits of pulmonary rehabilitation for health and also social problems to access to improve life, there are many investigations that we could continue discussing but we must ask ourselves: what is the true COST-UTILITY of implementing pulmonary rehabilitation? both for the patient and for each country and the reality depending on their economic development.

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