

Pulmonary rehabilitation: We can overcome the many ifs and buts

Sir,

The editorial comments made by Talwar D titled “Pulmonary rehabilitation: Too many ifs and buts” in your esteemed journal have spurred fruitful insights into many clinical aspects of provision of pulmonary rehabilitation (PR) services.^[1] We would like to offer our perspectives on overcoming the many ifs and buts.

We agree that within and beyond the rehabilitation fraternities, paucity of well-trained PR professionals, underrecognition of the need for PR services, and heterogeneous outcomes are mighty challenges.

The first step is to strengthen the training and knowledge of PR concepts. Using the International Classification of Functioning, Disability, and Health (ICF) framework, PR interest groups in each hospital should first categorize the common PR outcome measures to ICF components pertaining to body functions, activities, participations, and environmental factors for both the chronic obstructive pulmonary disease (COPD) and non-COPD cohorts.^[2] Based on the local availability of resources and trained personnel, PR practitioners and program designers should then integrate each ICF subcomponent with suitable validated outcomes into their research and clinical practice. We recognized that heterogeneity of outcomes reported in PR, and hence, analysis of systematic reviews and meta-analysis of at least moderate-quality PR studies might be one option to provide further insight into the choices of PR outcomes. PR outcomes consisted of patient-reported outcomes and physical clinical measures. Examples include the use of Borg scale for dyspnea and EuroQOL 5D for health-related quality of life in patient-reported outcomes and 6-min walk test for aerobic capacity and quadriceps twitch responses for strength assessment in clinical outcome measures.^[3]

Next, developing pulmonary telerehabilitation capabilities is critical. There has been leaping progress in this area since the COVID pandemic, with emerging new protocols, programs, and user-friendly devices such as respiratory monitors, activity trackers, and communication systems.^[4] We foresee value in analyzing these programs or protocols to evaluate if the methodologies described in these studies can be implemented in India and countries where PR is underemphasized. Various clinical and nonclinical

stakeholders would have to be involved in implementing the most practical and cost-effective PR programs.

Finally, the scope of PR can be expanded to the arena of non-COPD patients. PR in interstitial lung disease (ILD) has less robust data than COPD. Recently, the study of ILD patients in Singapore demonstrated that PR improves exercise tolerance, symptoms, and quality of life.^[5] Expanding the scope of PR to non-COPD patients not only potentially increases the utilization of PR but also enriches the experience of PR team in understanding ILD-specific outcome measures such as The King’s Brief ILD questionnaire and its minimal clinically important difference.^[5] We acknowledge that many patient-reported and physical outcomes relevant to COPD can be used in PR in ILD. We also observe that India has multiple ILD publications in recent years with positive PR outcomes and this is consistent with what we observed in our own center.

We congratulate Talwar D in his publication, highlighting the current state of art in India with regard to PR, and wish the author success in collating more PR data.

Acknowledgment

Both authors contributed equally to the writing of this article.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Submitted: 25-May-2021 Accepted: 30-May-2021 Published: 28-Dec-2021

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How to cite this article: Koh MM, Tan YL. Pulmonary rehabilitation: We can overcome the many ifs and buts. *Lung India* 2022;39:95-6.
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Quick Response Code: 	Website: www.lungindia.com
	DOI: 10.4103/lungindia.lungindia_299_21