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Submission template – COLUMN

Title	**Maximising Value in COPD: Everyone, Everywhere, Always**
Main Text	*Max 500 words without (sub)headings* *Cite hyperlinks (between brackets in the text) instead of references* You want value for money, right? What did you look for last time you reviewed a CT chest scan from a patient with COPD? A qualitative assessment of the extent and distribution of emphysema and the presence of bronchial wall changes, most likely. Exclusion of a suspicious nodule? Fissural integrity? Did you go on and think about co-morbidity? An enlarged pulmonary artery suggestive of pulmonary hypertension perhaps, or the presence and extent of coronary artery calcification to inform cardiovascular risk? And is that a hiatus hernia contributing to reflux? If we are really going to improve outcomes in COPD we need to be maximising the value from the investigations we perform. COPD, par excellence, is a condition associated with co-morbidity and we fail our patients if we don't provide an holistic assessment. But you get that, I know, you're a COPDologist like me. Recently (https://view-health-screening-recommendations.service.gov.uk/lung-cancer/) the UK recommended introduction of a lung cancer screening programme. This is important. Lung cancer outcomes in the UK lag behind other countries and diagnosing people earlier is associated with better survival. Risk factors for lung cancer and COPD are similar, and COPD itself both increases the risk of cancer and can complicate therapy. In a local pilot (https://pubmed.ncbi.nlm.nih.gov/35896207/), 47% of >10000 people attending for lung cancer screening had airflow obstruction characteristic of COPD, of whom 42% were previously undiagnosed despite symptomatic disease. It has to be a mistake to see lung cancer screening as a binary rule-out test for cancer, we must maximise the value from those scans which can inform on a problem that is particularly thorny – how to find the 'missing millions' living with undiagnosed COPD. Ideally lung cancer screening should comprise a holistic 'lung health check', but if programmes are not going to include spirometry then at least they should be reporting back on those with emphysema, who have demonstrable evidence of exposure-related

	lung disease and are therefore at high risk for COPD. Is that happening where you work? The challenges of COPD diagnosis are even more difficult in low- and middle-income countries (LMIC) where spirometry is a limited resource. We have recently (https://pubmed.ncbi.nlm.nih.gov/35015039/) shown that case-finding tools can identify those at high risk of airflow obstruction with reasonable discriminative accuracy. But fundamental questions remain – can such tools be implemented in routine healthcare settings in LMIC? And does diagnosing people with 'COPD' (and that's a diverse collection of conditions in LMIC settings) improve their health and productivity in setting where access to affordable medicines is limited, and availability of high-value interventions such as pulmonary rehabilitation is rare. In whichever context you work, maximise the value of assessments in COPD, and make the case for others to help us reach those living with COPD who are undiagnosed and therefore under-treated. Together, we can change the world.
Keywords (3)	*COPD; screening; Lung Cancer*
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Conflict of Interest statement	*I have received personal payment and payment to my employer for educational and advisory work from pharmaceutical companies that make medicines to treat COPD.*
Image caption	*Visible emphysema in a CT scan from a patient with lung cancer.*

IMAGE: visible emphysema in a CT Scan from a person with lung cancer.