



COPD Is a Modifiable Disease: Highlights from ERS 2026

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THE EUROPEAN Respiratory Society (ERS) Congress 2026 in Barcelona, Spain, reinforced a clear message: COPD is a modifiable disease. Presentations showed how outcomes can improve at every stage, from earlier diagnosis and structured review to the first replicated Phase III success for an anti-IL-33 biologic.

INTRODUCTION

Many people with COPD are diagnosed late, and many continue to exacerbate on treatment that has not been reviewed, or despite optimal management. With transformative biologic therapies now arriving, there is a generational opportunity to change this. At ERS 2026, two Abstracts Leading to Evolution in Respiratory Medicine Trials (ALERT) sessions captured both sides of that opportunity. The first showed what can be achieved by optimising care with existing tools. The second reported a new biologic for patients who exacerbate despite inhaled therapy. This article summarises these and other highlights, and considers what they mean for clinical practice.

TARGETED OPTIMISATION: DELIVERING GUIDELINE-BASED COPD MANAGEMENT

The PREVAIL cluster randomised trial, presented in the ALERT-1 session, evaluated CONQUEST, a quality improvement programme for high-risk COPD across 175

UK general practices.¹ The programme combined electronic record searches, case-finding spirometry in undiagnosed patients, remote specialist pharmacist review, and proactive follow-up. In intervention practices, moderate or severe exacerbations in the following 12 months were 13% lower, and complicated exacerbations were 26% lower. The benefit was greater in newly diagnosed patients, with reductions of 21% and 40%, respectively, and in patients receiving monotherapy or less at baseline, in whom complicated exacerbations fell by 45%. Increase in prescribing rates of single-inhaled triple therapies were striking in the intervention group.

Two real-world studies supported the PREVAIL message. In the Greek COCARE study, data-driven triage followed by targeted review applied in eight primary care settings improved guideline-based interventions, with improvement in CAT score and early (6-month) improvement in exacerbation and hospitalisation signals.² In Northern Ireland, a co-developed COPD review template was applied in 21 practices. Pharmacist-led reviews of triaged

patients combined COPD optimisation with cardiovascular risk assessment.³ In the initial cohort of 232 patients, 49% were commenced on single-inhaled triple therapy, 55% of current smokers were referred for smoking cessation, and 30% of patients had an indicated intervention for cardiovascular risk reduction. Respiratory antibiotic and oral corticosteroid prescriptions fell by more than half over the early follow-up period.

COPD DIAGNOSTIC DELAYS AND CHALLENGES: MISSED OPPORTUNITIES AND TRANSFORMATION REQUIREMENTS

An analysis of more than 55,000 patients from 129 Australian general practices showed how long diagnosis can take.⁴ Patients eventually diagnosed with COPD had a median of five respiratory consultations over almost 4 years from their first respiratory primary care encounter before diagnosis. Over half of patients prescribed a preventer inhaler had no coded respiratory diagnosis.

A UK survey of 233 healthcare professionals also explored COPD diagnosis, with only 6% of respondents noting no delays.⁵ Delays were attributed to delayed patient presentation, symptoms treated without COPD diagnosis considered, and long waits for tests or specialist review. Diagnostic pathway redesign was proposed, including development of spirometry alternatives which are accurate, acceptable, and feasible to implement and sustain with a whole-system pathway.

NEW APPROACHES FOR DIAGNOSIS AND CASE-FINDING

Real-world validation of a spirometry alternative, 'N-Tidal Diagnose' capnography, was reported in two abstracts by teams from the Netherlands.^{6,7} COPD versus healthy was classified by this 5-minute effort-independent test with 97.9% sensitivity and 93.0% specificity in a group of 254 characterised patients, and with 100% sensitivity and 78.7% specificity in the interim analysis of a prospective cohort of 126 patients who had been referred for spirometry to evaluate breathlessness, where COPD was suspected.

Early data from China suggest that smartphone-based AI-powered single time point cough analysis may allow COPD case-finding at a large population level. COPD was confirmed in 71 of 93 high-risk individuals referred for spirometry.⁸

Lung cancer screening programmes offer a valuable opportunity to identify undiagnosed respiratory disease. In the French LUCSO cohort, spirometry identified COPD in 20% of participants, and 82% of these cases were previously undiagnosed.⁹ In the Tees Valley, UK, a review of 21,237 screening CT reports identified severe emphysema in 2.3% of participants.¹⁰ Among 80 consecutive patients with severe emphysema, 55 were breathless, and 45 of these had CT features suitable for bronchoscopic lung volume reduction (LVR). The authors estimated that over one-third of screened patients with severe emphysema could warrant assessment for this treatment.





A London, UK, group additionally showed that a residual volume calculator, based on spirometry and demographic data, identified hyperinflation through lung cancer screening in patients with emphysema, with an area under the curve of 0.82.¹¹ This could help to prioritise patients for assessment where access to body plethysmography is limited. Both studies were retrospective, and CT or physiologic criteria alone do not confirm suitability for LVR. Nevertheless, they point to a practical pathway from screening to appropriate earlier access to an effective and underused intervention.

DETECTING EXACERBATIONS EARLIER

An oral presentation from London, UK, reported a winter remote monitoring pilot.¹² High-risk patients recorded symptom scores and clinical observations three times a week. Compared with the previous winter, exacerbations fell by a mean of 64%, with 350 fewer inpatient bed days for COPD-related admissions.

MUCOUS PLUGS: A RISK-MODIFIER AND POTENTIAL TREATABLE TRAIT

A number of abstracts reported on the utility of identification of mucus plugs on CT scanning. In a prospective Chinese cohort of 1,939 participants, mucous plugs on CT in three or more lung segments were associated with more moderate or severe

exacerbations in COPD (adjusted rate ratio: 1.51).¹³ In participants with preserved spirometry, the same burden of plugging was associated with progression to COPD over 3 years (18.2% versus 7.6%). Smaller plug burdens were not prognostic.

BIOLOGICS AND THE PATIENTS WHO NEED THEM

Real-world data on biologics in COPD is emerging. Typical themes include replication and, in some cases, more impressive benefit than preceding RCTs, including in patient cohorts who were trial ineligible. One study from six Italian centres described 40 patients receiving dupilumab who were older and had more severe airflow obstruction than typical trial populations. Early improvements in symptoms, lung function, and exacerbation profile were notable.¹⁴

Finally, the ALERT-2 session reported OBERON and TITANIA, replicate Phase III trials of the dual reduced and oxidised IL-33 blocker, tozorakimab.¹⁵ The trials enrolled 1,750 patients with COPD with exacerbations in the prior year despite standard of care, including current and former smokers, with no eosinophil count exclusions, who were randomised 1:1 to tozorakimab or placebo. Around 90% of participants were receiving triple therapy. Tozorakimab significantly reduced the annualised rate of moderate or severe exacerbations by up to 34% versus placebo. Benefit was seen across

eosinophil categories but was greatest at 300 cells/ μ L or more.

CONCLUSION

ERS 2026 reinforced that COPD is a modifiable disease. Many patients still present repeatedly before diagnosis, and many high-risk patients are never escalated. Structured, proactive care can, however, close these gaps and reduce exacerbations. Lung cancer screening offers a route to both earlier diagnosis and proactive pulling into LVR assessment pathways. New diagnostic and monitoring tools could widen access and accelerate case-finding and diagnosis. Mucus plugging on CT scan is emerging as a prognostic and stratifying feature, and potentially also as a treatable trait. For patients who continue to exacerbate despite optimised inhaled therapy, tozorakimab may offer a new option beyond Type 2 inflammation.

Enthusiasm was tangible throughout the congress, highlighted by the spontaneous applause across the room when the OBERON and TITANIA data were presented. There was a genuine sense of momentum improving the outlook for COPD care. Maintaining this trajectory will, however, require sustained collaboration across clinical, academic, and industry sectors. We must integrate transformation initiatives across entire care pathways rather than delivering them in isolation, ensuring the rapid adoption and rigorous evaluation of assistive technologies and evidenced therapies. Respiratory care pathways should be reoriented towards proactive, personalised, and guideline-based management, underpinned by better case-finding and data-driven care. Crucially, these interventions must be delivered equitably so that the benefits reach those with the greatest need. We have made undeniable progress, but there is much more to do.

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