Version 1.2 November 2016 Based on V9 Dudley COPD Treatment Guidelines

CHRONIC OBSTRUCTIVE PULMONARY DISEASE TREATMENT GUIDELINES

MOSS GROVE SURGERY

This has been produced as a Quick Reference Guide, based on Dudley COPD Guidelines V9.0 September 2016.
The purpose to assist Health Care Professionals, who are managing patients with a Diagnosis of COPD, to select an appropriate inhaler device.
There are many devices available, which has caused much confusion.
These guidelines use an A B C D approach adapted from GOLD 2015
The cornerstone of treatment in COPD is inhaled bronchodilators

Definition of COPD

Chronic Obstructive Pulmonary Disease (COPD), a common preventable and treatable disease, is characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients.
It is the fourth leading cause of death in the world (GOLD 2016)

A FULL CLINICAL HISTORY IS OF PARAMOUNT IMPORTANCE

DIAGNOSIS IS CONFIRMED USING POST BRONCHODILATOR SPIROMETRY RATIO (FEV1/VC x 100) <70%

FEV1 % Predicted	NICE 2010	GOLD 2015
≥80% (+symptoms)	MILD	1
50-79%	MODERATE	2
30-49%	SEVERE	3
<30%	VERY SEVERE	4

- Choose a drug based on the person's symptomatic response and preference,the drug's side effects, potential to reduce exacerbations and cost.
- Do not use oral corticosteroid reversibility tests to identify patients who will benefit from inhaled corticosteroids.
- Be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with inhaled corticosteroids and be prepared to discuss with the patients – consider osteoporosis risk – see local guidance including FRAX score
- Ensure all patients have a personal management plan.
- Smoking cessation is the only intervention that reduces the decline of lung function in COPD. Encourage all patients to stop smoking.
- Encourage all patients to exercise. If the MRC is ≥3, or the patient considers themselves functionally disabled, refer to Pulmonary Rehabilitation.
- Advise Flu and Puemonococcal immunisation
- Check inhaler technique and Compliance at every opportunity

Bronchodilators are the cornerstone of treatment for patients with COPD

Mucolytic Therapy

- Consider in people with a chronic productive cough and continue use if symptoms improve. Do not routinely use to prevent exacerbations.

Carbocisteine capsules or oral liquid: 750mg three times a day for 4 weeks (capsules 375mg: Liquid 250mg/5mls)

(If no benefit stop treatment).

If beneficial continue with 750mg twice a day .

Steam Inhalation can prove beneficial

Management of Acute Exacerbations

- Increase frequency of short acting Bronchodilators use & consider giving via a nebuliser
- Prednisolone 30mg once daily for 5-7 days
- Administer antibiotics in accordance with local guidelines

Oxygen Therapy

- Assess the need for oxygen therapy
- Oxygen saturations less than 93% breathing air
- Refer as per local guidelines

Reference: NICE clinical guideline (101) 2010 Gold 2015

ORAL THERAPY

Corticosteroids

- Maintenance use of oral corticosteroid therapy in COPD is not normally recommended
- Some people with advanced COPD may need maintenance oral corticosteroids if treatment cannot be stopped after an exacerbation. Keep the dose as low as possible, monitor for osteoporosis and offer prophylaxis.

Theophylline

- Offer only after trials of short- and long-acting bronchodilators or to people who cannot use inhaled therapy. **Prescribe by brand.**
- Theophylline can be used in combination with beta2 agonists and muscarinic antagonists.
- Take care when prescribing to older people because of pharmacokinetics, comorbidities and interactions with other medications.
- Reduce Theophylline dose if macrolide or fluroquinolone antibiotics (or other drugs known to interact) are prescribed to treat an exacerbation.

Stepping Down Treatment for Patients with COPD on High Dose Inhaled Corticosteroids (ICS)

Many patients with COPD are taking high dose ICS who may not require them

See Dudley Step down Guidelines for guidance on which patients to consider stopping ICS and how to stop

REMEMBER : Bronchodilators are the cornerstone of treatment for patients with COPD

COPD CHRONIC OBSTRUCTIVE PULMONARY DISEASE TREATMENT GUIDELINES

DUDLEY RESPIRATORY GROUP

Based on V 9 Dudley COPD Treatment Guidelines Sept 2016

MOSS GROVE SURGERY

Prescribe by brand

SHORT ACTING BRONCHODILATORS

SABA
Short Acting Beta$_2$ Agonists

Bricanyl Turbohaler 500mcgs

One puff as required

Terbutaline

Salbutamol MDI 100 micrograms

Two puffs as required

Salbutamol

SAMA
Short Acting Muscarinic Antagonists

Ipratropium 20 micrograms MDI

Two puffs four times a day

Ipratropium

LONG ACTING BRONCHODILATORS

A B C D

LAMA + LABA
in a combination inhaler

Duaklir Genuair 340/12

One puff twice daily

Aclidinium / Formoterol

REMEMBER:
When you start a **LABA+LAMA** combination inhaler
Then **STOP LABA** or **LAMA** or **SAMA** in separate inhalers

INHALED CORTICOSTEROIDS (ICS) in a combination Inhaler + Long Acting Muscarinic Antagonist

D

(ICS + LABA) in a combination inhaler + LAMA

Symbicort Turbohaler 400/12

One puff twice daily

Budesonide & Formoterol

800mcgs/day BDP

OR

Symbicort MDI 200/6

Two puffs twice a day

Budesonide & Formoterol

800mcgs/day BDP

+

Eklira Genuair 322 micrograms

One puff twice a day

Aclidinium Bromide

REMEMBER: when you start a (LABA+ICS) in a combination inhaler then **STOP LABA** in separate inhaler

SPACER DEVICES

Aerochamber Plus (Blue)

Aerochamber Plus with mask (Blue)

- Recommended for use with MDIs
- Aerochamber is compatible with Salbutamol & Symbicort MDIs
- Spacers should be replaced every 6-12 months

INTERMITTENT BREATHLESSNESS AND/OR EXERCISE LIMITED

SHORT ACTING BRONCHODILATORS **SABA** OR **SAMA**

- Smoking cessation
- Pulmonary rehabilitation
- Anxiety & depression
- Exercise
- Dietary advice
- Compliance & Inhaler technique

BREATHLESSNESS or 1 EXACERBATION

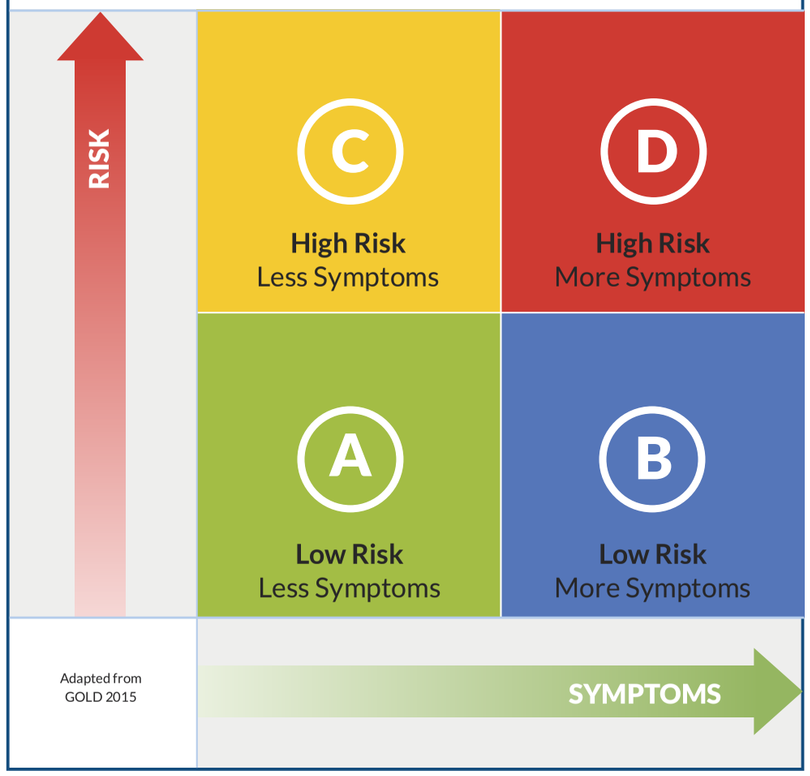
A → B

LAMA + LABA in a combination haler

BREATHLESSNESS with 2 or more EXACERBATIONS

C → D

ICS + LABA in a combination haler plus **LAMA**



KEY

SABA	-	Short Acting Beta$_2$ Agonist	**LAMA**	-	Long Acting Muscarinic Antagonist
SAMA	-	Short Acting muscarinic antagonist	**ICS**	-	Inhaled Corticosteroids
FEV$_1$	-	Forced Expiratory volume in 1st second	**MDI**	-	Metered Dose Inhaler
LABA	-	Long Acting Beta$_2$ Agonist	**BDP**	-	Beclometasone Equivalent

www.dudleyrespiratorygroup.org