Great Yarmouth & Waveney CCG – GOLD ABCD guidance – Inhaled treatment for COPD

NHS Great Yarmouth and Waveney Clinical Commissioning Group

Exacerbations

≥2 or > 1 leading to hospital admission

0 or 1 not leading to hospital admission

Group C – High Risk of Exacerbations, Less Symptoms

LAMA → Further Exacerbations/ Symptoms → **LAMA + LABA***

DPI
Braltus Zonda 1p od
Seebri Breezhaler 1p od

MDI
Spiriva Respimat 2p od

DPI
Anoro Ellipta 1p od
Ultibro Breezhaler 1p od

MDI
Spiolto Respimat 2p od

*LABA/ICS may be more appropriate in some patients but increased risk of pneumonia

Group D – High Risk of Exacerbations, More Symptoms

LAMA + LABA* → Further Exacerbations/ Symptoms → **ICS + LABA + LAMA****
(Triple therapy)

DPI
Anoro Ellipta 1p od
Ultibro Breezhaler 1p od

MDI
Spiolto Respimat 2p od

DPI
Trelegy Ellipta 1p od

pMDI
Trimbow 2p bd

*Some evidence to show LAMA/LABA is non-inferior and also superior to LABA/ICS in preventing exacerbations. LABA/ICS may be appropriate in some patients.
** Alternatively switch to LABA/ICS alone, (Relvar Elipta 1p od/ Fostair 100/6 2p bd) but no evidence that this results in better exacerbation prevention than LAMA/LABA

Group A – Low Risk of Exacerbations, Less Symptoms

SABA or SAMA

pMDI
SABA – salbutamol cfc free 100mcg 1-2p prn qds (+/- spacer)

DPI
SABA – Easyhaler salbutamol 100mcg 1-2pprn qds

Continue SABA for GOLD treatment options B, C and D if symptomatic benefit

Group B – Low Risk of Exacerbations, More Symptoms

LAMA (stop SAMA) OR **LABA** → Persistent symptoms → **LAMA + LABA***

DPI
Braltus Zonda 1p od
Seebri Breezhaler 1p od

MDI
Spiriva Respimat 2p od

DPI
Easyhaler Formoterol 1p bd

MDI
Atimos Modulite 1p bd (+/- spacer)

DPI
Anoro Ellipta 1p od
Ultibro Breezhaler 1p od

MDI
Spiolto Respimat 2p od

* step down to single bronchodilator if dual therapy does not improve symptoms

MRC 1-2 or CAT <10

MRC ≥3 or CAT ≥10

Symptoms

Adapted, with kind permission, from NEL CSU Anglia COPD guideline. SABA: Short Acting Beta Agonist. **SAMA:** Short Acting Muscarinic Antagonist. **ICS:** Inhaled Corticosteroid. **DPI:** Dry Powder Inhaler. **MDI:** Metered Dose Inhaler. **pMDI:** Pressurised Metered Dose Inhaler. **MRC:** Medical Research Council Dyspnoea Scale. **CAT:** COPD Assessment Test.

Key Points

- Advise all patients with COPD to stop smoking – refer to the local Stop Smoking Service if necessary.
- Provide pulmonary rehabilitation for all who need it – refer to JPUH Pulmonary Rehab service.
- Be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with ICS. Long-term use of ICS will contribute significantly to the already higher risk of osteoporosis in COPD patients
- Offer a one-off pneumococcal vaccination and an annual influenza vaccination to all patients with COPD.
- Review people with mild or moderate COPD at least once a year and those with very severe COPD at least twice a year[1].
- Ensure patients have a self-management plan detailing how to recognize and respond to the early signs of an exacerbation[2].

Inhaler licenses

Fostair and Symbicort pMDI are the only licensed MDI. DuoResp Spiromax inhalers are ICS/LABA combination inhalers licensed for use in COPD. Only high dose Symbicort and Seretide Accuhaler and low dose Relvar are licensed. Seretide Evohaler is unlicensed.

All remaining ICS/LABA combination inhalers are currently unlicensed in COPD.

If patient cannot use licenced device or suffers from excessive side effects from licensed product - consider using LABA/ICS combination MDI 'off license' with a spacer e.g. Sirdupla. Inform patient that treatment is off licence if appropriate.

Pulmonary rehabilitation (PR)

- PR should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above). The education element of PR can be offered to patients with an MRC grade 2 and above.
- PR is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.
- Refer patients who need pulmonary rehabilitation to JPUH PR service.

Oxygen

- Patients who are not hypoxic do not benefit from oxygen.
- Patients who are hypoxic with oxygen saturations of <92% when stable should be considered for long term oxygen.
- Patients should be assessed by the Respiratory Nurses at JPH - consider referral to secondary care first to ensure the patient has been medically optimised.

Advance planning and end of life care

- Offer discussions about advance care planning.
- Agree an anticipatory care plan for future exacerbations/ complications.
- Ensure end-of-life care is an integral component of the care plan of people with advanced COPD.

Oral corticosteroids[1]

- Maintenance use of oral corticosteroids in COPD is not recommended.
- Some people with advanced COPD may need maintenance treatment if therapy cannot be stopped after an exacerbation – refer to secondary care.
- Keep dose as low as possible, monitor for osteoporosis and offer prophylaxis.
- Issue and discuss Steroid Warning Card

Exacerbations[1]

- Patients need to have the local management plan booklet
- Give people at risk of exacerbations a course of antibiotic and corticosteroid tablets to keep at home (SOS pack)
- Patients should contact their practice when they start using an SOS pack. A review should occur before being given a replacement pack. (acute prescription)

Mucolytic therapy[1]

- Consider in people with a chronic productive cough and continue use if symptoms improve.
- Do not routinely use to prevent exacerbations.
- Step down to maintenance dose or stop once condition improves.

Criteria for specialist advice

Referral for advice, specialist investigations or treatment may be appropriate at any stage of disease, not just for people who are severely disabled.[1]

- Diagnostic uncertainty
- Onset of cor pulmonale
- Dysfunctional breathing
- Bullous lung disease
- Rapid decline in FEV1
- Haemoptysis
- The individual requests a second opinion
- Assessment for lung volume reduction surgery or lung transplantation
- Assessment for oxygen therapy, long-term nebuliser therapy or oral corticosteroid therapy
- Symptoms disproportionate to lung function deficit
- Onset of symptoms under 40 years or a family history of alpha-1 antitrypsin deficiency

References:
1. National Institute for Health and Clinical Excellence (NICE). Chronic Obstructive Pulmonary Disease (COPD) CG101. June 2010

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