Newcastle Gateshead CCG COPD Management Guidelines

IT IS ESSENTIAL THAT MANAGEMENT IS HOLISTIC AND DOES NOT FOCUS SOLELY ON INHALER THERAPY.

The most cost effective interventions in COPD are:

FLU VACCINATION

STOP SMOKING SUPPORT with pharmacotherapy

PULMONARY REHABILITATION

DIAGNOSIS

- Requires quality assured spirometry AND an appropriate history.
- Think asthma if: smoking history < 10 pack years, wheeze, atopy, early onset and symptom variability.
- Airflow obstruction only if FEV1/FVC ratio < 0.7 (or lower limit of normal).

INTERVENTIONS

VACCINATIONS	Pneumococcal vaccination and an annual influenza vaccination should be offered to all patients
SMOKING CESSATION	Offer referral for all COPD patients who smoke.
PULMONARY REHABILITATION	Offer referral for all those whose lifestyle is limited by breathlessness.
CO-MORBIDITIES	**Identify and treat:** • anxiety and depression – these frequently occur, affect quality of life and are drivers for admission. Consider referral for CBT. • heart failure • ischaemic heart disease • osteoporosis • anaemia • bronchiectasis
EXERCISE	Encourage in all but the most severe of cases.
DIET	Discuss diet if BMI > 25kg/m^2, or dietitian referral if <20kg/m^2

TREATMENT OF COPD EXACERBATIONS:

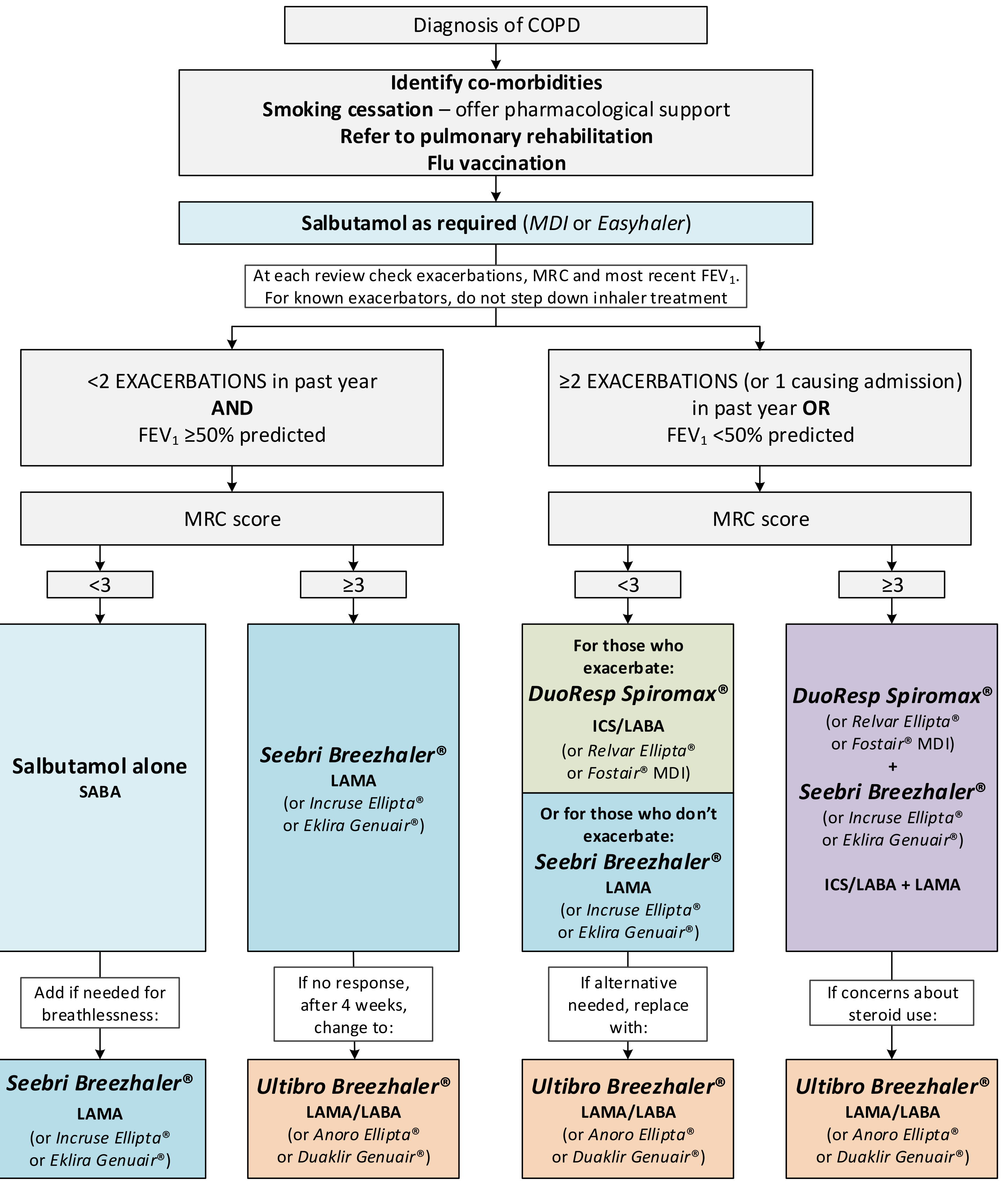
- If increase in breathlessness: Prednisolone 30mg daily for 7 days
- If sputum changes from normal colour:
  - **Doxycycline 200mg on day one then 100mg daily for a total of 5 days or**
  - **Amoxicillin 500mg three times a day for 5 days**
- Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations or antibiotics in the last 3 months. If resistance factors are present, consider **co-amoxiclav 625mg three times a day for 5 days** (NB increased *C.diff* infection risk)
- Practices need a system for monitoring the use of rescue medications and the condition of their patients while they are using them. These medications should only be prescribed in conjunction with a self-management plan and should never be on repeat prescription.

PRESCRIBING INFORMATION

- Tailor the device to the patient and check inhaler technique at every opportunity.
- For patients currently on steroid containing inhalers who you think no longer need them, withdraw steroids stepwise and slowly over a 3 month period whilst monitoring symptoms closely (in case they actually have chronic asthma and would therefore need the steroid).
- **Carbocisteine** can be trialled for 1-2 months in those with a chronic productive cough or during an exacerbation for those with frequent exacerbations. If large sputum volumes consider bronchiectasis and refer for respiratory opinion and / or CT scan).

COPD Management Guidelines

NHS
Newcastle Gateshead
Clinical Commissioning Group



PRESCRIBE ALL INHALERS (EXCEPT SALBUTAMOL) BY BRAND NAME TO ENSURE CONSISTENCY OF INHALER DEVICE

MRC Dyspnoea Scale	
1	Not troubled by breathless except on strenuous exercise
2	Short of breath when hurrying on a level or when walking up a slight hill
3	Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace
4	Stops for breath after walking 100 yards, or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing/undressing

COPD Inhaler Guide – September 2016

Preferred inhaler choices for Newcastle Gateshead CCG are shown below. To avoid confusion all inhalers other than salbutamol should be prescribed by brand name.
MDI = metered dose inhaler; DPI= dry powder inhaler

Class	Drug	Brand	Dose
SABA (Short-acting Beta2-agonist)	Salbutamol 100mcg/inhalation MDI or DPI	Various brands including: ***Ventolin Evohaler®*** ***Easyhaler Salbutamol®***	TWO inhalations up to FOUR times a day
	Others include: Terbutaline (*Bricanyl Turbohaler®*)		
LAMA (Long-acting Antimuscarinic)	Glycopyrronium 44 micrograms/ inhalation DPI	***Seebri Breezhaler®***	ONE inhalation ONCE daily
	Umeclidinium 55 micrograms/ inhalation DPI	***Incruse Ellipta®***	ONE inhalation ONCE daily
	Aclidinium 322 micrograms/ inhalation DPI	***Eklira Genuair®***	ONE inhalation TWICE daily
	Others include: Tiotropium (*Spiriva Handihaler®*) – for existing patients only		
LAMA/LABA (Long-acting Antimuscarinic & Long-acting Beta2 Agonist)	Glycopyrronium & indacaterol 43/85 micrograms/inhalation DPI	***Ultibro Breezhaler®***	ONE inhalation ONCE daily
	Umeclidinium & vilanterol 55/22 micrograms/inhalation DPI	***Anoro Ellipta®***	ONE inhalation ONCE daily
	Aclidinium & formoterol 340/12 micrograms/inhalation DPI	***Duaklir Genuair®***	ONE inhalation TWICE daily
ICS/LABA (Inhaled Corticosteroid & Long-acting Beta2 Agonist)	Budesonide & formoterol 160/4.5 & 320/9 micrograms/inhalation DPI	***DuoResp Spiromax®***	**160/4.5:** ONE inhalation TWICE daily **320/9:** ONE inhalation TWICE daily
	Fluticasone furoate & vilanterol 92/22 micrograms/inhalation DPI	***Relvar Ellipta®***	ONE inhalation ONCE daily
	Beclometasone & formoterol 100/6 MDI	***Fostair®***	**100/6:** TWO puffs TWICE daily
	Others include: Budesonide/formoterol (*Symbicort Turbohaler®*) – for existing patients only		

Useful links for patients:

- My Lungs My Life (http://mylungsmylife.org/)
- British Lung Foundation Breathe Easy support groups (https://www.blf.org.uk/support-for-you/breathe-easy)