Gateshead Clinical Commissioning Group

Chronic Obstructive Pulmonary Disease (COPD) guidelines

Implementation date: October 2011

Updated: October 2014

Review date: October 2016

This guideline has been prepared and approved for used within Gateshead in consultation with Gateshead CCG and Secondary Care Trusts.

Approved by:

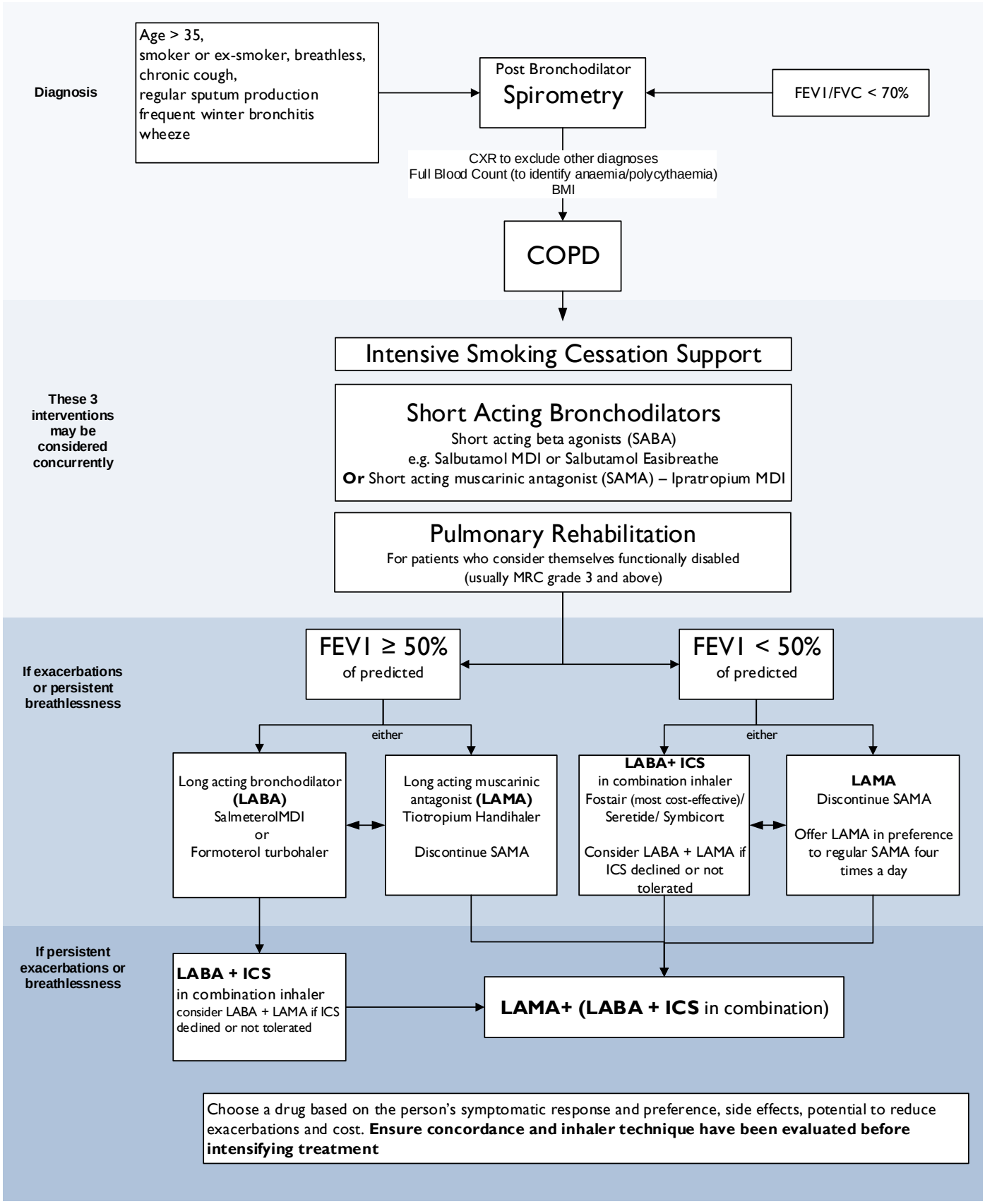
Committee	Date
Gateshead Medicines Management Committee	12/11/2014
Newcastle Gateshead Alliance CCGs Optimisation of Medicines Pathways and Guidelines Committee	20/11/2014

This guideline is not exhaustive and does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Full details of contra-indications and cautions for individual drugs are available in the BNF or in the Summary of Product Characteristics (available in the Electronic Medicines Compendium) www.emc.medicines.org.uk

Gateshead COPD Treatment Guide

(Click here for NICE guidance (CG101) and NICE pathway)



Exacerbation is defined as rapid and sustained worsening of symptoms beyond normal day-to-day variation

ICS = Inhaled Corticosteroid, SABA = Short acting bet agonists, SAMA = Short acting muscarinic antagonist, LABA = Long acting bronchodilator, LAMA = Long acting muscarinic antagonist

Chronic productive cough in COPD

Offer trial of mucolytic therapy – such as carbocisteine. Continue only if symptomatic improvement. Do not routinely use mucolytics to prevent exacerbations in people with stable COPD.

Treatment of exacerbations

Prednisolone 30mg daily for 7 days if increased breathlessness.
Antibiotic if sputum is purulent. The North East and Cumbria antibiotic guideline for primary care (2014) recommends: Amoxicillin 500mg three times a day for 5 days **OR** Doxycycline 200mg first day then 100mg daily for 4 days if penicillin allergy.
Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations or antibiotics in the last 3 months. If resistance risk factors are present, consider co-amoxiclav 625mg three times a day for 5 days.

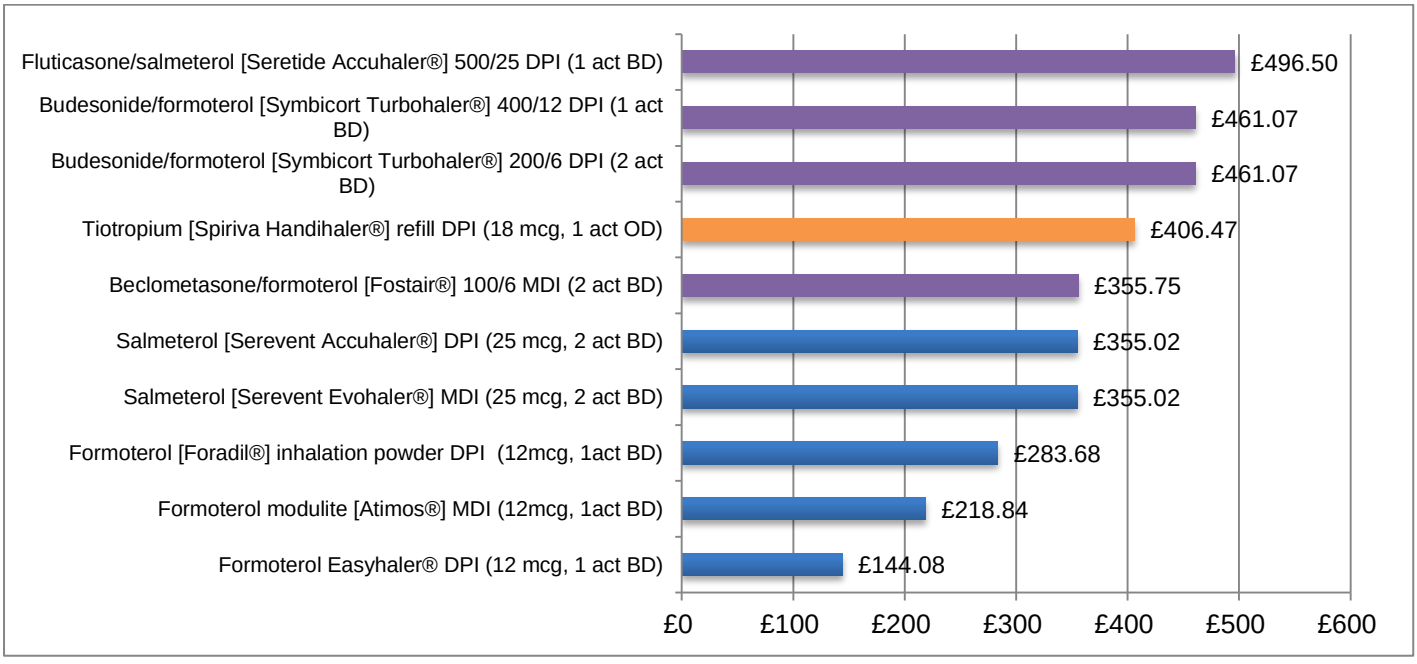
Review after an exacerbation

1. **Optimise inhaled therapy**
   - Check compliance
   - Assess inhaler technique
   - Review medication for COPD (as per Gateshead COPD Treatment Guide above)
2. **Offer pneumococcal vaccination and annual influenza vaccination**
3. **Give self management advice**
   - Quitting smoking – offer help to stop smoking
   - Remaining active – if MRC score is less than 3, refer to Gateshead exercise programme. If MRC score is 3 or more, refer to **pulmonary rehabilitation** (see NICE CG101 (table 1) for MRC dyspnoea scale)
   - Give patient **COPD Action Plan** (this is a self management plan available on GIN and in printed format)
   - Issue **COPD rescue pack** containing prednisolone and antibiotic (see above treatment of exacerbations)
   - If a patient is very anxious, consider referral to Respiratory Occupational Therapist
4. **Consider osteoporosis prophylaxis**

   If a patient has had 4 or more courses of prednisolone in the previous 12 months then they are at risk of osteoporosis.
   - If the patient is less than 65 years of age and no fragility fracture, refer for open access DEXA scan
   - If the patient is 65 years of age or older, or under 65 years of age with previous fragility fracture, then DEXA scan is not necessary prior to starting drug treatment for the prevention of steroid induced osteoporosis.

   Please refer to Gateshead CCG guideline for the management of osteoporosis in primary care (2013) for more information.

Cost of treatment for 1 year (based on July 2014 prices)
(ICS/LABA combinations, LAMAs and LABAs)



Doses given do not imply therapeutic equivalence. Adapted from RDTC cost comparison charts July 2014.
Click here for up to date cost-comparison charts from RDTC.