COPD Treatment Pathway*

SMOKING CESSATION SERVICE  Lifestyle Advice  Diet/Exercise  Influenza vacc (annual)  Pneumococcal vacc  Psychological Issues

Pulmonary rehabilitation – (Ensure treatment is optimised)  Hull No: 01482 247111  East Riding No: 01482 347929

PHARMACOLOGICAL TREATMENT

Review all new treatment after one month and CHECK INHALER TECHNIQUE

prn short acting β² agonist (SABA)  If controlled on LAMA monotherapy switch to Respimat/Braltus

Symptoms not controlled or repeated presentation

Add LABA/LAMA **

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| Spiolto Respimat®  
(olodaterol + tiotropium)  
2 puffs once daily | “Soft mist” inhaler                  | Activation of inhaler required          |
| Ultibro Breezehaler®  
(indacaterol + glycopyronium)  
1 puff once daily | Best evidence base                        | Device requires loading               |
| Anoro 55/22 Ellipta®  
(vilanterol + umeclidinium)  
1 puff once daily | Device                                      | ? effect on dyspnoea and exacerbations |
| Duaklir 340/12 Genuair®  
(formoterol + aclidinium)  
1 puff twice daily | Strong evidence and feedback on correct inhalation | Requires extended inspiratory flow to activate device |

In-check device may be useful in assessing inhaler technique

Clinical suspicion of asthma supported by history of raised eosinophils > 0.3 (see overleaf for further information)

Consider non-acid reflux and aspiration

Azithromycin tabs 250mg OD (or Erythromycin 250mg BD) for 1 month and review

Roflumilast 500mcg OD

Consider referral for specialist review

No  Yes

Asthma COPD Overlap

Add Beclometasone eg QVAR or change LABA/LAMA to Trimbow triple therapy

**long acting β² agonist/long acting muscarinic antagonist

**Chronic Obstructive Pulmonary Disease**

**THINK OF THE DIAGNOSIS OF COPD**
Over age 35
Smokers or ex-smokers
Have any:
  o Exertional dyspnoea
  o Regular sputum production
  o Frequent winter bronchitis
  o Wheeze
**And** have no features to suggest asthma eg high blood eosinophils or elevated exhaled nitric oxide

**Perform Chest X-ray and spirometry if COPD seems likely**
Airflow obstruction is post bronchodilator
FEV$_1$:FVC ratio <0.7

**Inhaled corticosteroids**
Blood eosinophil count may be a useful clue to an asthmatic component in COPD the so called Asthma COPD Overlap Syndrome. Other older terms are late onset asthma or intrinsic asthma. Blood eosinophil count $>0.3$ suggests steroid responsiveness. Blood eosinophils vary dependant on time of day, comorbidities, and concurrent therapy so an overall assessment of historical blood counts may be most reliable indication.

If considering discontinuing inhaled corticosteroid, please note it is currently unclear the best way to withdraw inhaled corticosteroids. Suggest switching to LABA/LAMA inhaler and review in two weeks by Community Pharmacist.

**Patients who should be assessed for Long Term Oxygen Therapy**
Oxygen saturations <92% breathing air when stable
There is no evidence to support the use of ambulatory oxygen

**Referral for special advice**
Diagnostic uncertainty
Persistent symptoms
Dysfunctional breathing or excessive cough
Patient aged under 40 years or a family history of alpha-1 antitrypsin deficiency
Assessment for nebuliser therapy
Assessment for lung volume reduction surgery or lung transplant

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