

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 β^2 agonist (SABA) – if controlled on LAMA monotherapy switch to Respimat/Braltus

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Symptoms not controlled or repeated presentation

Add LABA /LAMA **	PROS	CONS
 Spiolto Respimat ▼ <i>(olodaterol + tiotropium)</i> 2 puffs once daily	“Soft mist” inhaler	Activation of inhaler required
 Ultibro Breezhaler ▼ <i>(indacaterol + glycopyrronium)</i> 1 puff once daily	Best evidence base	Device requires loading
 Anoro 55/22 Ellipta ▼ <i>(vilanterol + umeclidinium)</i> 1 puff once daily	Device	? effect on dyspnoea and exacerbations
 Duaklir 340/12 Genuair ▼ <i>(formoterol + aclidinium)</i> 1 puff twice daily	<div style="text-align: center; border: 1px solid black; padding: 2px;">Twice daily</div> Strong evidence and feedback on correct inhalation	Requires extended inspiratory flow to activate device

In-check device may be useful in assessing inhaler technique

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If continued exacerbations, consider

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

Consider non-acid reflux and aspiration

No

Yes

Asthma COPD Overlap

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

Roflumilast 500mcg OD

Consider referral for specialist review

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

**long acting β^2 agonist/long acting muscarinic antagonist

Chronic Obstructive Pulmonary Disease

THINK OF THE DIAGNOSIS OF COPD

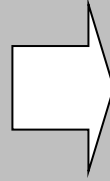
Over age 35

Smokers or ex-smokers

Have any:

- Exertional dyspnoea
- Regular sputum production
- Frequent winter bronchitis
- 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
FEV₁: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

Hull & East Riding Stop Smoking Service Freephone 0800 915 5959

East Riding Health Trainers Freephone:0800 9177752

<http://www2.eastriding.gov.uk/living/health-and-wellbeing/improving-your-health/>

CHCP Pulmonary Rehab Team: 01482 247111

Palliative Care Management Guidelines can be found at:-

<https://www.hey.nhs.uk/wp/wp-content/uploads/2016/03/commencingPalliativeCareMedicinesJIC.pdf>

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