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

Symptoms not controlled or repeated presentation

In-check device may be useful in assessing inhaler technique

Add LABA /LAMA **	PROS	CONS
 **Spiolto Respimat**▼ (*olodaterol* + *tiotropium*) **2 puffs once daily**	"Soft mist" inhaler	Activation of inhaler required
 **Ultibro Breezehaler**▼ (*indacaterol* + *glycopyrronium*) **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**	Twice daily Strong evidence and feedback on correct inhalation	Requires extended inspiratory flow to activate device

MUCOLYTICS

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

Roflumilast 500mcg OD

No → Consider referral for specialist review

Yes → Asthma COPD Overlap → Add Beclometasone eg QVAR or change LABA/LAMA to Trimbow triple therapy

Approved by Hull & East Riding Prescribing Committee: March 2018.* Commissioned by Hull CCG. Review date: March 2021

**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
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

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

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