This guideline is currently under review. Please continue to use this version until the review has been completed

South East London Integrated Guideline for the Management of COPD

Treatment of **tobacco dependence** is an important clinical intervention in these (and all) patients. Ask about smoking at every opportunity, offer very brief advice http://www.ncsct.co.uk/publication_very-brief-advice.php and Carbon Monoxide (CO) measurement when appropriate. Patients are significantly more likely to quit if treated with drug therapy and psychological support. Quit smoking therapies (including varenicline) are safe and effective in patients with mental illness but may need more careful monitoring (eg patients with a history of psychiatric illness such as schizophrenia, bipolar disorder and major depressive disorder, or depression). Useful resources are available at: http://www.londonsenate.nhs.uk/helping-smokers-quit/

- All patients with an MRC score ≥3 (see below) and/or have had an exacerbation in the last 3 months will benefit from **Pulmonary Rehabilitation**
- All patients should be asked to demonstrate their **inhaler technique** regularly and **adherence** be established *before* stepping up therapy
- All patients should have a written **self-management plan**, instructions for/access to a **rescue pack** and when indicated, an **inhaled corticosteroid card** (annotated with the symbol Ψ below)

All patients should have their FEV_1, FEV_1 % predicted and FEV_1/FVC ratio recorded accurately and **reviewed annually**

Step up if patient's breathlessness worsens

Acute therapy	Initial regular therapy	Dual bronchodilation
As Required SABA (Inhaled Short-Acting β_2-Agonist)	**Regular LAMA (Inhaled Long-Acting Muscarinic Antagonist)**	**Add Regular LABA (Inhaled Long-Acting β_2-Agonist)**
Salbutamol MDI 100mcg one - two puffs PRN +/- aerochamber plus®	**Seebri Breezhaler®▼** Glycopyrronium 44mcg one capsule od	**Ultibro Breezhaler®▼** Indacaterol/Glycopyrronium 85/43mcg one capsule od
Salbutamol Easyhaler® 100mcg one - two puff PRN	**Eklira Genuair®▼** Aclidinium 322mcg one puff bd	**Duaklir Genuair®▼** Aclidinium/Formoterol 340/12mcg one puff bd
Salbutamol breath actuated device 100mcg one - two puffs PRN	**Incruse Ellipta®▼** Umeclidinium 55mcg one puff **od**	**Anoro Ellipta®▼** Vilanterol/Umeclidinium 22/55mcg – one puff od
	Spiriva Handihaler® Tiotropium 18mcg one capsule od	Choose from devices above based on inhaler technique

Consider referral to specialist in line with local policy

Exacerbations should be coded appropriately and their frequency reviewed as part of the patient's annual assessment
Oxygen saturation should be checked at **each** review. If <92% on air and/or signs of cor pulmonale, refer to specialist oxygen assessment team

Further Pharmacological therapy dependant on symptoms:

- ✓ A mucolytic (e.g. carbocisteine 375-750mg TDS) for copious, thick and difficult to clear sputum
- ✓ Addition of an ICS to the LABA/LAMA can be considered for those with an FEV_1<50% predicted AND experiencing ≥2 exacerbations per year (e.g. **Fostair MDI®** Beclometasone/Formoterol 100/6mcg - two puffs bd via "aerochamber plus®" and a **LAMA** from the list OR **Relvar Ellipta®▼** Vilanterol/Fluticasone Furoate 22/92mcg one puff od$^{\Psi}$ and **Incruse Ellipta®▼** Umeclidimium 55mcg one puff od)

MRC breathlessness scale:

1. Not troubled by breathlessness except on strenuous exercise
2. Short of breath when hurrying or walking up a slight hill
3. Walks slower than contemporaries on the level because of breathlessness, or has to stop for breath when walking at own pace
4. Stops for breath after about 100 m or after a few minutes on the level
5. Too breathless to leave the house, or breathless when dressing or undressing

Produced by the SEL Responsible Respiratory Prescribing Group. Approved by the SEL Area Prescribing Committee: May 2016. Review date: April 2018

This guideline aims to support responsible respiratory prescribing.

- ✓ A change in inhaler device should only occur upon consultation and agreement with the patient e.g. as part of their annual review. Unsupported "switching" may lead to loss of symptom control and unnecessary anxiety for the patient or their carer
- ✓ To avoid confusion, inhalers should be prescribed by brand. Where the device is comparable between brands (currently only seretide and sirdupla MDI), it may be more cost effective to prescribe the cheaper one, but this should still be by brand
- ✓ ICS cards are indicated for patients prescribed ≥1000mcg beclometasone dipropionate or equivalent (annotated overleaf with the symbol Ψ) https://www.networks.nhs.uk/nhs-networks/london-lungs/documents/high-dose-inhaled-corticosteroid-alert-card-order-form

There are several common steps to all inhaler devices, but always ensure you are confident and competent to teach the devices you prescribe:

1. Prepare inhaler device – e.g. remove cap
2. Prepare ("load") dose – e.g. shake inhaler, insert and pierce capsule or "click" the dose lever
3. Breathe out (not into inhaler) as far as is comfortable
4. Put lips around mouthpiece
5. Breathe in correctly. This is the commonest error, but simply determined by the device *type*. All inhalers are either an **aerosol** or a **dry powder** (see below)
6. Remove inhaler from mouth and hold breath for 5-10 seconds or as long as is comfortable
7. Repeat as directed and finish

Adapted with permission from: http://simplestepseducation.co.uk/

Aerosol devices

"*Slow and Steady*" inspiration

MDI

Aerochamber plus

Easi-breathe®

Dry Powder devices

"*Quick and Deep*" inspiration

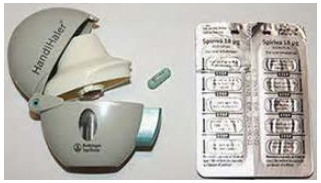
Easyhaler®

Breezhaler®

Ellipta®

Genuair®

Handihaler®



NOTE: The inhaler colour will vary depending on content

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