Step Down guidance

Stepping-down combination ICS/LABA asthma inhaler therapy: Adults ≥17yrs

Important

Complete asthma control needs to be achieved for at least 12 weeks before attempting to step patients' down\(^2,3\). Stepping patients down before 12 weeks of complete asthma control can lead to exacerbations and hospital admissions. Table 1 (below) defines the levels of asthma control.

NICE guidance\(^2\) recommends that clinicians should stop or reduce the dose of medicines in an order that takes into account their clinical effectiveness when introduced, side effects and the patient’s preference. This local step down guidance only refers to ICS/LABA inhalers, but other drugs (e.g. montelukast, tiotropium) may be stopped first if deemed appropriate.

When stepping patients down or switching therapy, prescribers should keep device changes to a minimum and consider the beclometasone dipropionate (BDP) equivalence of different inhaled corticosteroids\(^4\). Table 2 demonstrates the variation in BDP equivalence across different inhaled corticosteroids.

What do the guidelines say about stepping-down inhaled corticosteroids?

Reductions should be considered every three months, but only if patients have complete asthma control\(^1,2\). When reducing inhaled corticosteroids (ICS) clinicians should remember that patients deteriorate at different rates. If asthma is controlled with a combination ICS/LABA inhaler, the preferred approach is to reduce the ICS by approximately 50% whilst continuing the LABA at the same dose. Clinicians should note that with Fostair\(^5\) and DuoResp Spiromax\(^6\) this is only achievable by prescribing the ICS and LABA as two separate devices. An alternative is to half the daily dose of combination treatment, although this approach is more likely to lead to loss of asthma control.

BTS guidance advises that combination devices may increase adherence to therapy\(^1\). As LABA monotherapy can increase the risk of asthma-related deaths, prescribers should consider each patient on an individual basis taking into account patient preference, therapeutic need and the likelihood of adherence with all asthma therapy. Any decision should be taken after having a full discussion with the patient covering the potential consequences; such as a reappearance of symptoms and what to do if they occur\(^1\).

If control is maintained after stepping-down, further reductions in the ICS should be attempted. The dose of ICS should be adjusted to achieve the lowest dose required for effective asthma control\(^2\).

---

### Table 1: LEVELS OF ASTHMA CONTROL\(^1\)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Well Controlled</th>
<th>Partly Controlled</th>
<th>Uncontrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime symptoms more than twice per week</td>
<td>None of these</td>
<td>1-2 of these</td>
<td>3-4 of these</td>
</tr>
<tr>
<td>Any activity limitation due to asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any night waking due to asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliever needed more than twice per week</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: VARIATIONS IN BDP EQUIVALENCE

<table>
<thead>
<tr>
<th>Inhaled Corticosteroid</th>
<th>Equivalence to 400mcg beclometasone dipropionate (BDP)/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beclometasone - Clenil(^6)</td>
<td>400mcg</td>
</tr>
<tr>
<td>Beclometasone - Fostair(^6)</td>
<td>No 400mcg equivalent: 200mcg Fostair(^5) = 500mcg BDP</td>
</tr>
<tr>
<td>Beclometasone - Qvar(^6)</td>
<td>200mcg Qvar(^6) = 400-500mcg BDP (\text{refer to SPC})</td>
</tr>
<tr>
<td>Budesonide - Pulmicort(^7)/Fobumix(^7)/DuoResp(^7)/Symbicort(^7)</td>
<td>400mcg</td>
</tr>
<tr>
<td>Fluticasone - Flixotide(^7)/Fusacomb(^7)/AirFluSa(^7)/Seretide(^7)</td>
<td>200mcg</td>
</tr>
<tr>
<td>Ciclesonide - Alvesco(^8)</td>
<td>160-240mcg</td>
</tr>
<tr>
<td>Mometasone - Asmanex(^8)</td>
<td>200mcg</td>
</tr>
</tbody>
</table>
Ascertain whether the patient has achieved complete asthma control for at least 3 months

**Step the patient down**
1. Identify which combination inhaler product the patient is using and select the relevant flow-chart for this (page 3 & 4)
2. Identify the patient’s current dose and locate where this is positioned in the flow-chart
3. Follow the arrow and prescribe the next recommended inhaler(s).

**Do not step the patient down**
1. Check inhaler technique
2. Check exposure to trigger factors
3. Check adherence to therapy and consider any issues which may affect compliance

*If these have been excluded, step-up therapy*

**Clinicians should consider:**
Patients achieve complete asthma control at different rates. Clinicians should have a discussion with the patient to decide whether to trial the current therapy for longer or to step-up again.

**Suggested discussion points with patient:**
1. Are there any factors affecting adherence to therapy e.g. polypharmacy, social reasons or beliefs?
2. Are there any issues affecting compliance e.g. dexterity?
3. Is the patient exposed to trigger factors e.g. smoking, pets, pollen or stress?
4. Are there any lifestyle points to consider where asthma stability is crucial e.g. impending exam
5. How long did it take the patient to achieve complete asthma control last time?
6. What would be the potential consequences of an exacerbation and does the patient know what to do if this occurs?
7. What would the patient prefer to do?

**Action:**
Clinicians should use their professional judgement to decide whether to continue trialling the current therapy, or to step-up again. If continuing on the current therapy for longer, the clinician should advise the patient to monitor their symptoms and short-acting bronchodilator use, and review the patient again in 1 month. Patients should be advised to return to clinic if their symptoms become problematic within this time. *Refer to a specialist if necessary.*

---

2. NICE guideline NG80: Asthma: Diagnosis, monitoring and chronic asthma management. November 2017

Adapted from Bristol guidance developed by J. Gibbs. Acknowledgement to Devon guidelines.
Asthma Step-down Guide: Seretide®, AirFluSal®, Fusacomb Easyhaler® and Fostair®

NB: Seretide Evohaler = AirFluSal MDI (only available as 250 and 125 strengths)

Seretide Accuhaler = Fusacomb Easyhaler (only available as 500 and 250). Step down to lowest strength would require brand/device change

---

**Key:**

**Cost:** 30-day cost without a spacer (Drug Tariff 03/2020)
* Total daily dose inhaled corticosteroid, in terms of beclometasone dipropionate (BDP) equivalent.
† First line choices ‡ Cost-effective choice if Fluticasone/salmeterol MDI required

---

All patients with asthma should be provided with a short-acting beta₂ agonist (salbutamol or terbutaline) to aid in the event of an acute exacerbation.
Symbicort 400/12 or Fobumix 320/9®

- 1 puff bd
  - (800mcg BDP* equiv./day + 24mcg formoterol/day)

Symbicort 200/6 or Fobumix 160/4.5®

- 2 puffs bd
  - (800mcg BDP* equiv./day + 24mcg formoterol/day)

Symbicort 100/6 or Fobumix 80/4.5®

- 2 puffs bd
  - (400mcg BDP* equiv./day + 12mcg formoterol/day)

Qvar Easi-Breathe® or MDI 50mcg

- 2 puffs bd (£4.72)
  - OR
  - Clenil Modulite® 100mcg
  - 2 puffs bd (£4.45)
    - OR
    - Beclometasone Easyhaler 200mcg
    - 1 puff bd (£4.48)
      - OR
      - Fluticasone 50 Evohaler®
      - 2 puffs bd (£6.53)
        - OR
        - Fluticasone 100 Accuhaler®
        - 1 puff bd (£8.00)

All patients with asthma should be provided with a short-acting beta₂ agonist (salbutamol or terbutaline) to aid in the event of an acute exacerbation.
DuoResp Spiromax 320/9
1 puff bd
(800mcg BDP* equiv./day + 24mcg formoterol/day)

DuoResp Spiromax 160/4.5
1 puff bd
(400mcg BDP* equiv./day + 12mcg formoterol/day)
NOTE – Lower LABA and ICS

Qvar Easi-Breathe® or MDI
50mcg†
2 puffs bd (£4.72)
OR
Clenil Modulite® 100mcg
2 puffs bd (£4.45)†
OR
Beclometasone Easyhaler
200mcg
1 puff bd (£4.48)†
OR
Fluticasone 50 Evohaler®
2 puffs bd (£6.53)
OR
Fluticasone 100 Accuhaler®
1 puff bd (£8.00)

Key:
Cost: 30-day cost without a spacer (Drug Tariff 04/18)
* Total daily dose inhaled corticosteroid, in terms of beclometasone dipropionate (BDP) equivalent.
† 1st line choice

All patients with asthma should be provided with a short-acting beta₂ agonist (salbutamol or terbutaline) to aid in the event of an acute exacerbation.