NHS
Derby and Derbyshire
Clinical Commissioning Group

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[2,3,4]. 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® and DuoResp Spiromax® 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]

Assessment of current clinical control (preferably over 4 weeks)

Characteristic	Well Controlled	Partly Controlled	Uncontrolled
Daytime symptoms more than twice per week	None of these	1-2 of these	3-4 of these
Any activity limitation due to asthma			
Any night waking due to asthma			
Reliever needed more than twice per week			

Table 2: VARIATIONS IN BDP EQUIVALENCE

Inhaled Corticosteroid	Equivalence to 400mcg beclometasone dipropionate (BDP)/day
Beclometasone - Clenil®	400mcg
Beclometasone - Fostair®	No 400mcg equivalent: 200mcg Fostair®= 500mcg BDP
Beclometasone - Qvar®	200mcg Qvar® = 400-500mcg BDP (refer to SPC)
Budesonide - Pulmicort®/Fobumix®/DuoResp®/Symbicort®	400mcg
Fluticasone - Flixotide®/Fusacomb®/AirFluSal®/Seretide®	200mcg
Ciclesonide - Alvesco®	160-240mcg
Mometasone - Asmanex®	200mcg

Instructions: How to step patients down

Ascertain whether the patient has achieved complete asthma control for at least 3 months

YES

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).

YES

Review the patient in 3 months

Has the patient achieved complete asthma control in the last 3 months (see Table 1)?

(If you previously stepped the patient up to cover the hay fever season and wish to step them down again, review the patient in 1 month rather than 3 months).

NO

YES

Step the patient down again and repeat cycle

NO

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

NO

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.***

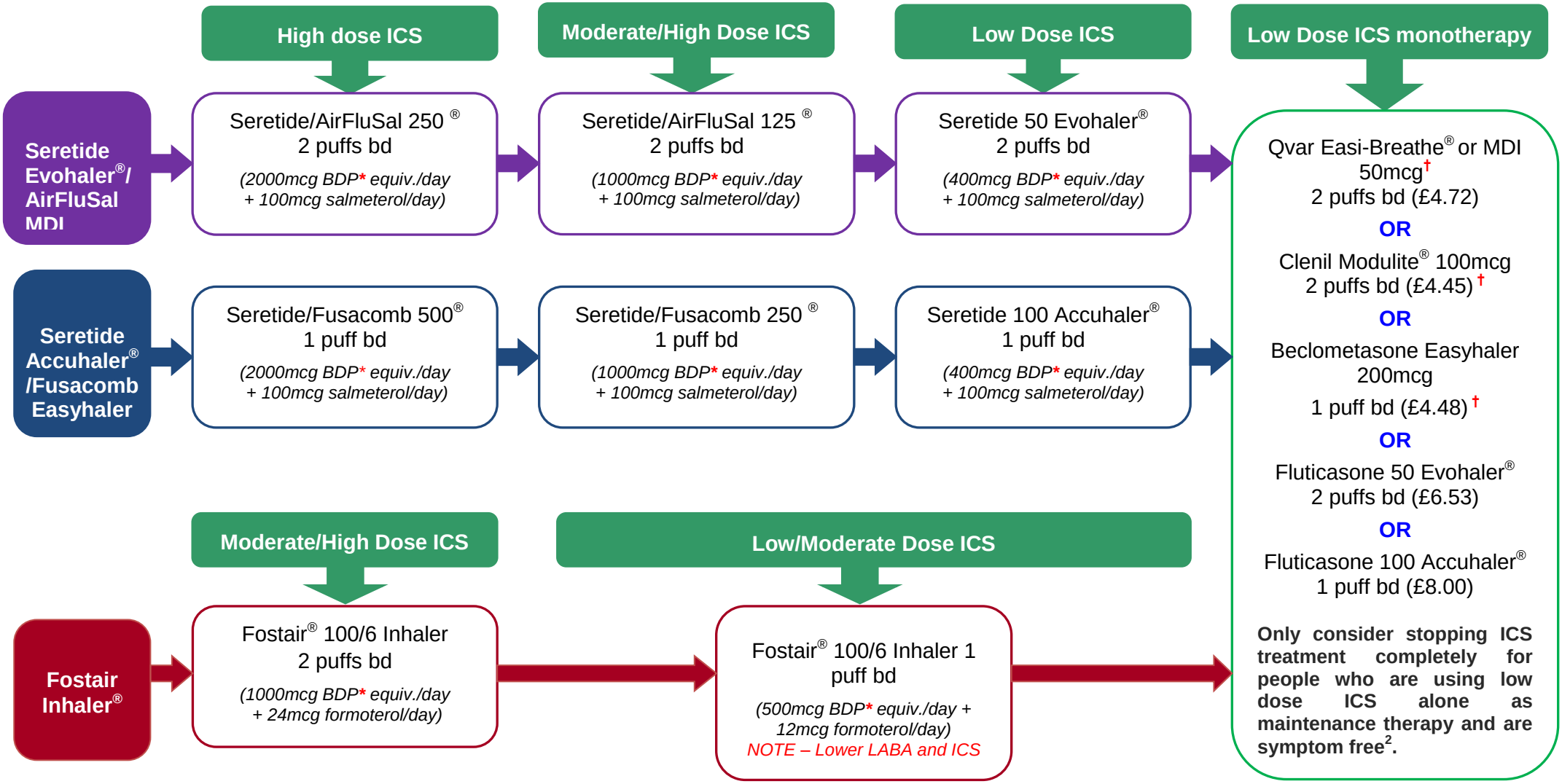
1. British Thoracic Society. Scottish Intercollegiate Guidelines Network. British guideline on the management of asthma. 2016. https://www.brit-thoracic.org.uk/standards-of-care/guidelines/btssign-british-guideline-on-the-management-of-asthma/ (accessed 05/04/18)
2. NICE guideline NG80: Asthma: Diagnosis, monitoring and chronic asthma management. November 2017
3. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. 2018 update. http://ginasthma.org/2018-gina-report-global-strategy-for-asthma-management-and-prevention/ (accessed 05/04/18)
4. National Institute for Health and Clinical Excellence. Inhaled corticosteroids for the treatment of chronic asthma in adults and in children aged 12 years and over. NICE technology appraisal guidance 138.2008 Mar. http://www.nice.org.uk/TA138

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**

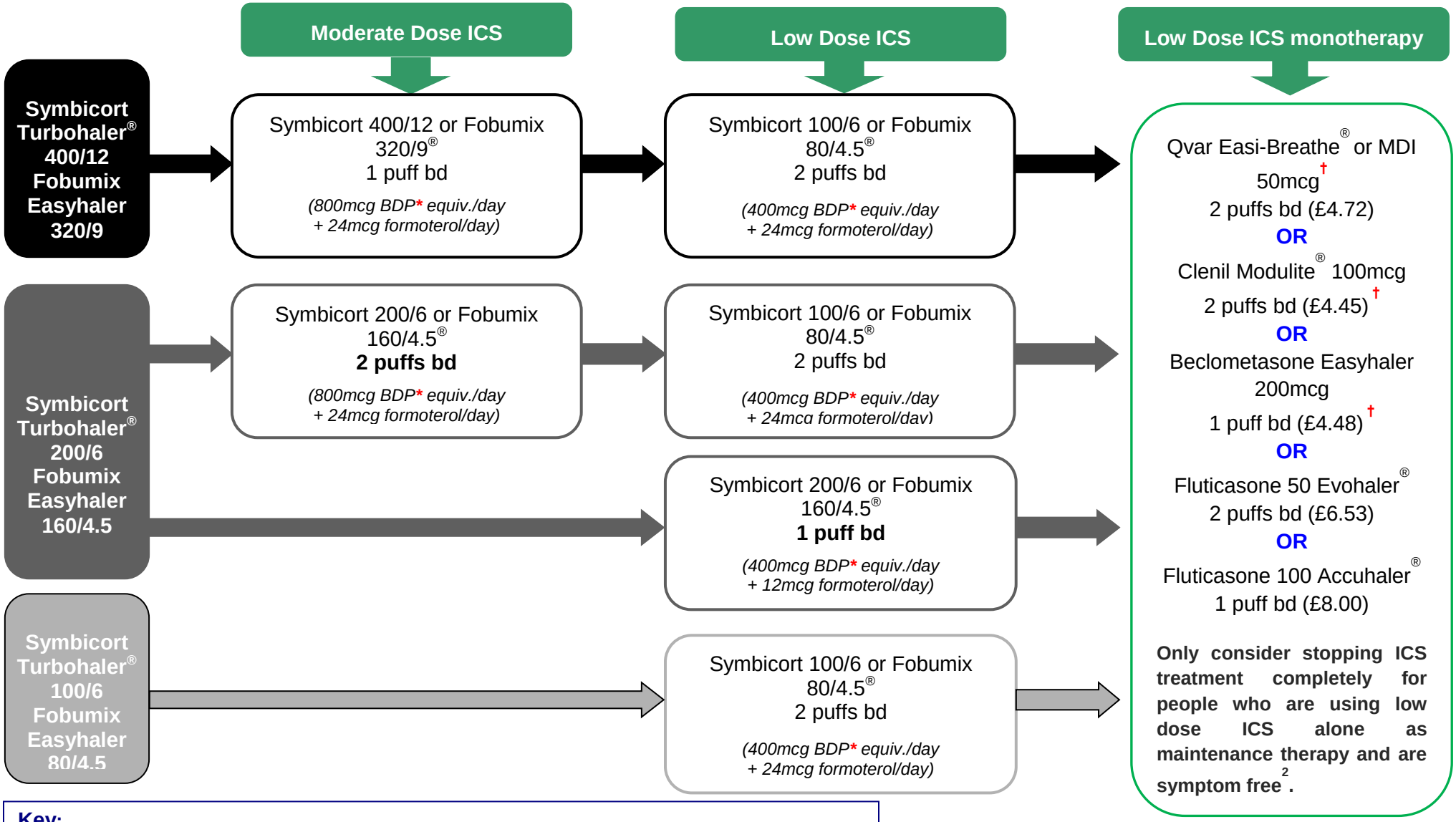
All patients with asthma should be provided with a short-acting beta$_2$ agonist (salbutamol or terbutaline) to aid in the event of an acute exacerbation.

Asthma Step-down Guide – Symbicort Turbohaler®/Fobumix Easyhaler®†

Note: all doses as for asthma maintenance therapy, not asthma maintenance and reliever therapy.

To step down from Symbicort 400/12 (or Fobumix 320/9) at a dose of **2 puffs bd**, start at top LHS below. Both LABA and ICS will be reduced.

NB: This flowchart can be used for either Symbicort or Fobumix – Symbicort 400/12 = Fobumix 320/9; Symbicort 200/6 = Fobumix 160/4.5; Symbicort 100/6 = Fobumix 80/4.5



Key:

Cost: 30-day cost without a spacer (Drug Tariff 04/18)

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† 1st line choice

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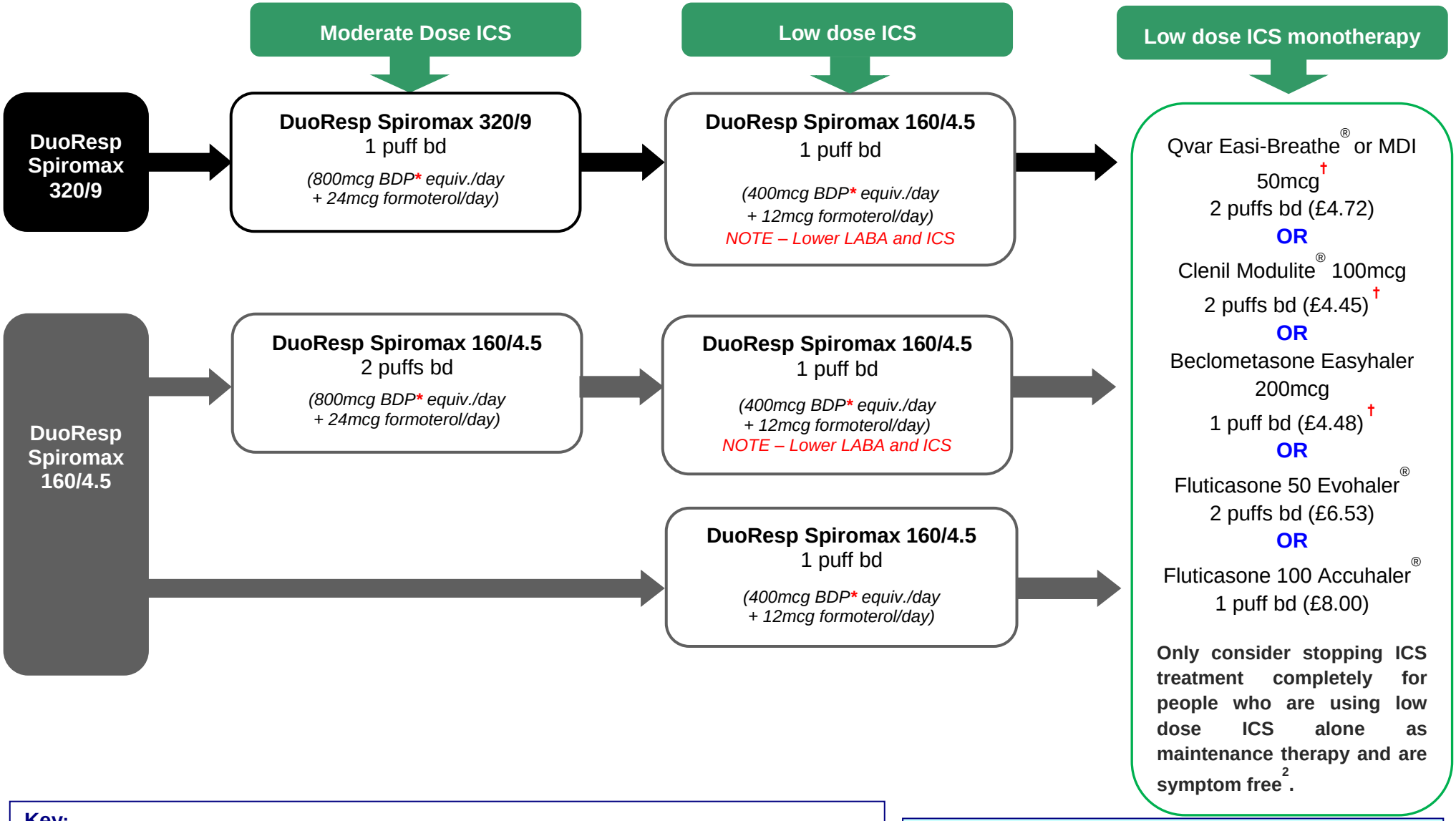
Asthma Step-down Guide – DuoResp Spiromax ®

Note: all doses as for asthma maintenance therapy, not asthma maintenance and reliever therapy.

To step down from DuoResp Spiromax320/9 **2 puffs** bd start at top LHS below. Both LABA and ICS will be reduced



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