Derbyshire Medicines Management UPDATE

www.derbyshiremedicinesmanagement.nhs.uk

Reviewing COPD – an update on current issues

Derbyshire COPD Guidelines can be found here **Updated: December 2019 Date of review: November 2022**

COPD is predominantly caused by smoking and is a major cause of morbidity and mortality in the UK.

- **Smoking cessation is the only intervention that reduces decline in FEV_1.**
- **Drug treatment is aimed at managing symptoms. No drug is perfect; all have limitations and due to the nature of the disease, patients will deteriorate with time. Achievable targets need to be set and effectiveness of treatment measured against these targets. *If a new treatment does not improve a patient's quality of life, then stop it and try something else; don't keep adding in.***

Management of all COPD patients

- **Pulmonary rehabilitation** offer to all patients who consider themselves functionally limited by breathlessness or fatigue, including those who have had a recent hospitalisation for an acute exacerbation. Physiotherapist support for breathing techniques. For Southern Derbyshire and Erewash see ImpACT+ for further information. For North Derbyshire see Respiratory & pulmonary therapy service :: Derbyshire Community Health Services (dchs.nhs.uk)
- **Smoking cessation** – Provide Derbyshire Helpline number **0800 0852299** or, for Derby City patients, the Live Well Derby number **01332 641254**
- **Annual Flu** vaccination + once only Pneumococcal vaccination
- Advice and support on exercise and nutrition
- Patient information and self-management plan should be offered to assist patients in self care
- Psychological services for anxiety and depression related to COPD. See DCHS Health Psychology Derbyshire (dchs.nhs.uk)
- Social services and occupational therapy for support with activities of daily living.

The online COPD Assessment Test (CAT) may be used, to assess the effectiveness of COPD treatments with improvements in symptoms, activities of daily living, exercise capacity and rapidity of symptom relief, in addition to lung function tests. The CAT assessment questionnaire can be found online.

Ask the patient to give examples - if a treatment is not providing significant benefit, is it worth continuing it?

Before moving to the next stage in the therapeutic management of COPD always check the patient's adherence to treatment and inhaler technique.

Spirometry training – are you able to produce a valid reading? Do you know how to interpret it? Please contact the respiratory team for information on training.

For patients prescribed new inhalers consider referring to the community pharmacist for the New Medicines Service (NMS); this will help to ensure that the patient gets the full benefit from their new treatment.

Prescribing notes – For further information see JAPC COPD guidelines

LABA + LAMA combinations

- The evidence shows that LABA/LAMA provides the greatest benefit to quality of life in patients with no asthmatic features, is better than other inhaled treatments for many individual outcomes (such as reducing the risk of moderate to severe exacerbations) and is the most cost-effective option.

LABA + ICS combinations

- Most trials exclude patients with a combined diagnosis of COPD and asthma → No direct evidence. NICE recommend LABA/ICS for patients who have asthmatic features/features suggesting steroid responsiveness. NICE do not recommend using "oral corticosteroid reversibility tests" to identify patients who should be prescribed ICS.
- Be vigilant of potential adverse effects with ICS, e.g. pneumonia, anxiety, sleep disorders, behavioural changes, including psychomotor hyperactivity and irritability (predominantly in children), depression, aggression. Patients should be informed of the potential risks.

LABA + LAMA + ICS

- Stronger evidence shows that triple therapy benefits patients with asthmatic features taking LABA/ICS combinations, compared to LABA/LAMA.
- For patients who are taking LABA/ICS **offer** LAMA+LABA+ICS and for patients taking LABA/LAMA **consider** LAMA+LABA+ICS if their day-to-day symptoms continue to adversely impact their quality of life, **or** they have a severe exacerbation (requiring hospitalisation), **or** they have two moderate exacerbations within a year.
- Document the reason for continuing ICS use in clinical records and review at least annually. Consider stepping down treatment with an ICS - see local guidance for further details

Oral corticosteroids

- Not normally recommended however may be prescribed on specialist recommendation, may require osteoprotection.

Oral prophylactic antibiotic therapy - Azithromycin on respiratory specialist advice only (see COPD guidelines).

Theophylline - Offer only after inhaler therapy has been optimised. See SPS drug-monitoring for theophylline.

Mucolytics

- For chronic cough productive of sputum, consider N-acetylcysteine (NACSYS) 600mg OD or carbocisteine capsules /sachets 750mg TDS for 6-8 weeks then 750mg BD if improvement in sputum production and reduction in viscosity. Do not routinely use mucolytic to prevent exacerbations in people with stable COPD. Mucolytic therapy should be stopped if there is no benefit after a 4 week trial.

Management of stable COPD

Confirm diagnosis of COPD

Fundamentals of COPD care

- Offer treatment and support to stop smoking
- Offer pneumococcal and influenza vaccinations
- Offer pulmonary rehabilitation if indicated
- Co-develop a respiratory action plan
- Optimise treatment for co-morbidities

Check inhaler technique and compliance with particular device using In-check DIAL at annual review. If a patient is unable to use a particular device satisfactorily, then an alternative device should be sought.
Use COPD assessment tool (CAT) to assess the clinical response at baseline and when changing treatment. These treatments and plans should be revisited at every review

Start inhaled therapy only if:

- All the above interventions have been offered (if appropriate) and
- Inhaled therapies are needed to relieve breathlessness or exercise limitation.

Offer SABA or **SAMA (to use if needed)**
SABA should continue through all stages of symptoms
(Salamol MDI 100mcg 2 puffs PRN = £1.46/device)
SAMA (Ipratropium CFC free, MDI 20mcg 2 puffs PRN or QDS = £5.56/device)

Patient is limited by symptoms or has exacerbations despite treatment

If exacerbations continue review as per protocol for frequent exacerbators (p9).

South – discuss patient at virtual MDT clinic or refer to ImpACT service

North – refer to the community teams

No asthmatic features or features suggesting steroid responsiveness [a]

Asthmatic features or features suggesting steroid responsiveness [a]

Offer LABA + LAMA (£390/pa)
Spiolto Respimat (softmist), Duaklir Genuair (DPI), Ultibro Breezhaler (DPI) , Anoro Ellipta (DPI), Bevespi Aerosphere (MDI)
Choice should be based on patient tolerance, ease of use, and environmental impact of the inhaler device.
DPI preferred if clinically appropriate

Consider LABA + ICS[b]

Fobumix easyhaler DPI
(budesonide /formoterol) **(£258/pa)** Or
Luforbec MDI
(beclometasone/ formoterol 100/6) (£246/pa)
for patients requiring an MDI

Patient still limited by symptoms

Patient has 1 severe or 2 moderate exacerbations within a vear

Patient still limited by symptoms or has 1 severe or 2 moderate exacerbations within a year

Consider 3-month trial of **LAMA + LABA + ICS [b,c]**
In a combination inhaler

If no improvement, revert to LABA+LAMA

Consider

Offer

LAMA + LABA + ICS [b,c] (as a combination inhaler) Options include:

- **Trimbow NEXThaler DPI ((**Beclometasone 88mcg, Formoterol 5mcg, glycopyrronium 9 mcg) (£534/pa)
- **Trelegy DPI (**Fluticasone furoate 92 mcg, Vilanterol 22 mcg, Umeclidinium 65 mcg) **(£534/pa)**
- **Trimbow MDI (**Beclometasone 87mcg, Formoterol 5mcg, glycopyrronium 9 mcg) **(£534/pa)**
- **Trixeo aerosphere MDI** (Budesonide 160mcg/ formoterol 5mcg/ glycopyrronium 7.2 mcg) **(£534/pa)**

Explore further options if still limited by breathlessness or subject to frequent exacerbations - review diagnosis and consider referring to local COPD clinic.

[a] asthmatic features/features suggesting steroid responsiveness in this context include any previous secure diagnosis of asthma or atopy, a higher blood eosinophil count (Local expert opinion suggests a plasma eosinophil >0.3 x 10^9/l is suggestive of asthmatic features, substantial variation in FEV1 over time (at least 400ml) or substantial diurnal variation in peak expiratory flow (at least 20%) .
[b] Be aware of an increased risk of side effects (including pneumonia) in people who take ICS.
[C] document in clinical records the reason for continuing ICS treatment
NICE recommendations - '**offer**' reflects a strong recommendation, usually where there is clear evidence of benefit. '**Consider**' reflects a recommendation for which the evidence of benefit is less certain.

NICE recommends for patients using long-acting bronchodilators outside of the current recommendations and whose symptoms are under control, have the option to continue treatment until both, they and their clinician/ healthcare professional agree it is appropriate to change.