Optimisation of inhaled corticosteroids (ICS) in COPD ICS + LABA + LAMA ICS + LABA (Triple Therapy **Derby and Derbyshire Integrated Care Board** Does the patient have asthma? Continue ICS and • Documented history of asthma, with or without atopy (review if diagnosis is titrate to the lowest correct. Note: consider diagnoses made in people under 40 more likely to be licensed dose in COPD correct) YES to prevent • A large degree of reversibility of airflow limitation (>15% and 400mL in postairways bronchodilator FEV1) Does the patient have elevated blood eosinophils (>0.6 X 10⁹/L) (as per exacerbations and / or asthma specialist) symptoms and monitor for potential ICS-related **Further Assessment** adverse events. Does the patient have a high exacerbation risk? Continued • >2 exacerbations or >1 exacerbation leading to hospitalisation in the previous exacerbation No YES 12 months? despite biomarker may indicate lack - AND of efficacy of ICS Does the patient have elevated or need for blood eosinophils? additional therapy • >0.3 X 10⁹/L? No See ICS step-down inhaler flow chart guide and record CAT or MRC score before changing treatment Review every 4 weeks - Consultation with monitoring clinician including assessment of pulmonary function using spirometry (if deterioration in breathlessness with an increase in the MRC or CAT score) Interim call with patient (approx. 2 weeks) to check compliance and ensure stability. Patient should be encouraged to contact monitoring clinician if any worsening of symptoms or conditions. If stable or Improved Worsening?

Continue with LABA/LAMA (optimised bronchodilation)

Reassess need for ICS use if:

- moderate or severe exacerbations
- airflow limitation worsening

(FEV1 decrease >200 mL)

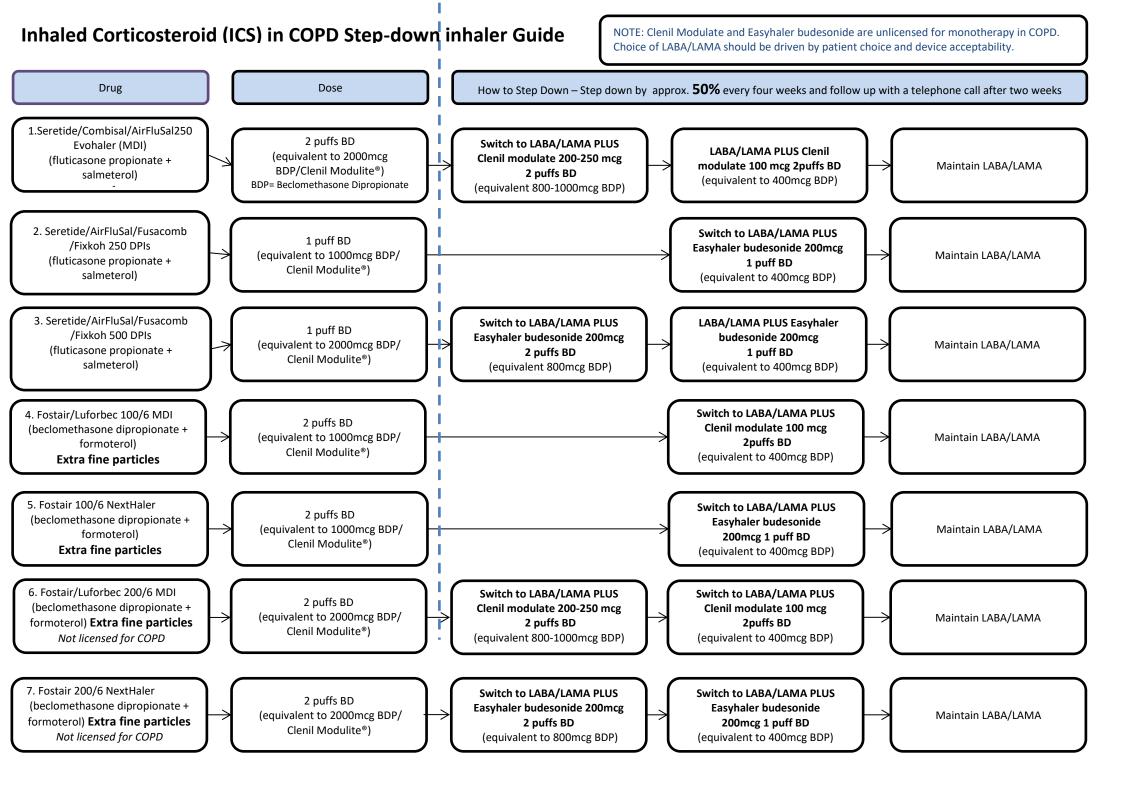
Increase in MRC or CAT score

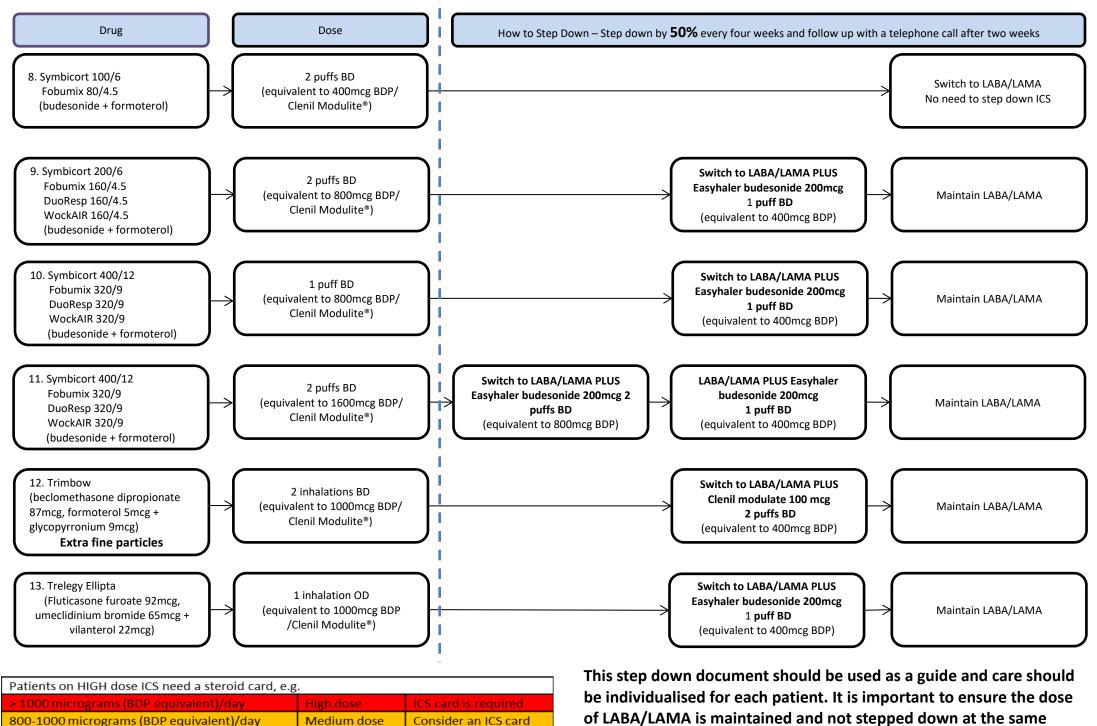
At 6 months - Follow-up with monitoring clinician for full clinical review

See the patient

- twice yearly during the first year of ICS withdrawal,
- followed by an annual review if the patient's COPD is stable and exacerbation-free

If unable to step down ICS therapy, stabilise patient on appropriate ICS dose before considering triple therapy





< 800 micrograms (BDP equivalent)/day

Low dose

No ICS card is required

be individualised for each patient. It is important to ensure the dos of LABA/LAMA is maintained and not stepped down at the same time. Please ensure the following are checked prior to prescribing: Inhaler technique and use of in-check device.

Steroid Dose Comparison

Table 1 demonstrates the variation in BDP equivalence across different inhaled corticosteroids

Table 1: VARIATIONS IN BDP EQUIVALENCE	
Inhaled Corticosteroid	Equivalence to 400mcg beclometasone dipropionate (BDP)/day
Beclometasone - Clenil®	400mcg
Beclometasone - Fostair®/Luforbec Extra fine particles	No 400mcg equivalent: 200mcg Fostair®= 500mcg BDP
Beclometasone - Qvar®/ Kelhale Extra fine particles	200mcg Qvar® = 400-500mcg BDP (refer to SPC)
Budesonide - Pulmicort®/DuoResp®/Symbicort/WockAIR/Fobumix	400mcg
Fluticasone propionate – Flixotide®/AirFluSal/ Seretide/Fixkoh /Fusacomb/ Combisal/	200mcg
Ciclesonide - Alvesco®	160-240mcg
Mometasone - Asmanex®	200mcg