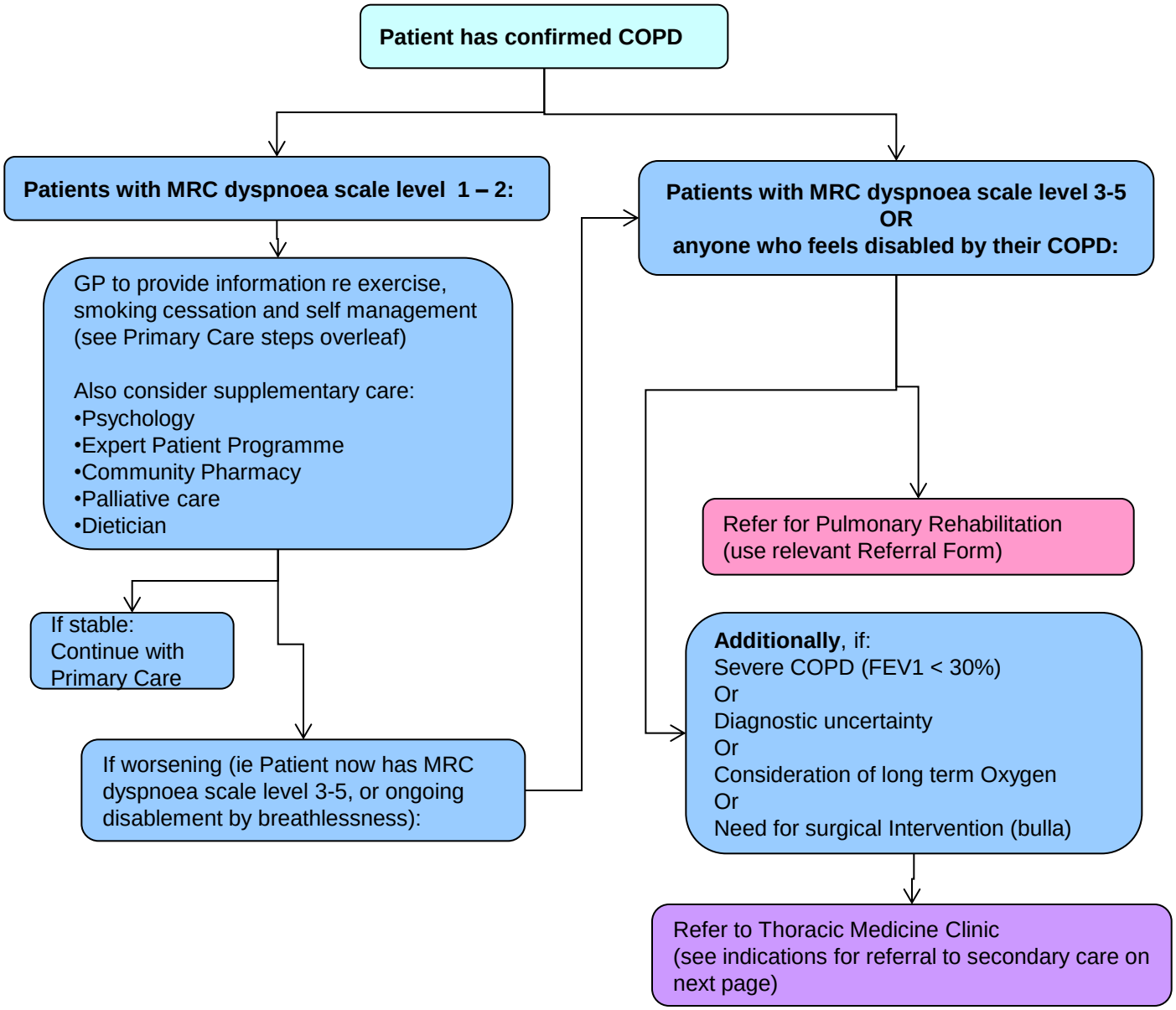
MANAGEMENT OF STABLE COPD

RSP-1 Protocol and Pathway - Respiratory Medicine Specialty (29/03/2011)



NB: Throughout treatment, consider mediation (as overleaf) and NICE Guidelines

MRC dyspnoea scale: Grade

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 level ground because of breathlessness, or has to stop for breath when walking at own pace
4. Stops for breath after walking about 100m or after a few minutes on level ground
5. Too breathless to leave the house, or breathless when dressing or undressing

Key

Patient presents | GP level intervention | Alternative Outpatient Service | Acute hospital | Red flag

CODP Clinical Management Guideline - Adults Version 0.1

Primary Care Steps to take:

- **Give advice to STOP SMOKING**
- Offer influenza vaccination (annually)
- Offer Pneumococcal vaccine (if not previously vaccinated, see BNF)
- Check inhaler technique
- Assess osteoporosis risk
- Give Exercise advice
- Perform Spirometry
- Calculate BMI and give appropriate advice
- Identify and manage anxiety / depression if present
- Consider bronchiectasis if large amounts of sputum daily or frequent infections
- Agree Care Management Plan with patient
- Give self-management advice and give Patient Infection Leaflet

Medicinal Treatment

Step 1

As required inhaled short acting B2-agonist Salbutamol 200mcg QDS up to QDS via MDI + spacer **AND / OR** As required inhaled short acting anticholinergic Ipratropium bromide 20-40mcg up to QDS via MDI + spacer

Step 2

Offer once-daily long-acting muscarinic antagonist (LAMA) in preference to four-times-daily short-acting muscarinic antagonist (SAMA) to people with stable COPD who remain breathless or have exacerbations despite using short-acting bronchodilators as required, and in whom a decision has been made to commence regular maintenance bronchodilator therapy with a muscarinic antagonist.

In people with stable COPD who remain breathless or have exacerbations despite using short-acting bronchodilators as required, offer the following as maintenance therapy:

- if FEV1 ≥ 50% predicted: **either** long-acting beta2 agonist (LABA) **or** LAMA
- if FEV1 < 50% predicted: **either** LABA with an inhaled corticosteroid (ICS) in a combination inhaler, **or** LAMA.

NB. Be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with inhaled corticosteroids and be prepared to discuss with patients.

Step 3

In people with stable COPD and an FEV1 ≥ 50% who remain breathless or have exacerbations despite maintenance therapy with a LABA:

- consider LABA+ICS in a combination inhaler
- consider LAMA **in addition to** LABA where ICS is declined or not tolerated.

Step 4

Offer LAMA **in addition to** LABA+ICS to people with COPD who remain breathless or have exacerbations despite taking LABA+ICS, irrespective of their FEV1.

Consider LABA+ICS in a combination inhaler **in addition to** LAMA for people with stable COPD who remain breathless or have exacerbations despite maintenance therapy with LAMA irrespective of their FEV1.

The choice of drug(s) should take into account the person's symptomatic response and preference, and the drug's potential to reduce exacerbations, its side effects and cost.

Step 5

Options include one or more of the following:

- Referral for Pulmonary Rehabilitation (if not already done)
- Trial of oral slow release theophylline
- Referral to respiratory specialist
- Nebuliser trial
- Long Term Oxygen Therapy Assessment

For full prescribing information please refer to current BNF / manufacturer's information

Referral indications to Intermediate care COPD Team:

- Diagnostic uncertainty remains after spirometry, symptom profile, peak flow diary and reversibility testing.
- 2 or more exacerbations annually despite optimised therapy.
- Housebound with SBOT / LTOT and / or nebuliser
- Pulmonary Rehabilitation

Referral indications to Secondary care specialist respiratory team include:

- Diagnostic uncertainty
- Disease onset at <40 years
- Review for severe COPD
- Haemoptysis
- Rapidly progressive course of disease (decline in FEV1, worsening breathlessness, decreased exercise tolerance, unintentional weight loss)
- Need for O2 therapy
- Cor pulmonale
- Nebuliser trial (if not available in primary care)
- Possible indication for surgery
- Frequent infections
- Symptoms disproportionate to lung function deficit
- Pulmonary Rehabilitation (if not available in primary care)

LABA = Long-acting $ß_2$-agonist, BDP= Beclometasone dipropionate; FP=Fluticasone; BUD=Budesonide; QVAR® (CFC-free BDP) Use spacer device with MDI.