# Guidelines for the diagnosis and management of COPD







Vale of York Harrogate and District York Teaching Hospital

## **Confirm diagnosis**

Consider HF, bronchiectasis, asthma, FEV<sub>1</sub>/FVC ratio <70%

### Patient identification by:

Risk assessment – Post bronchodilator spirometry for all patients >age of 35 with a smoking history of 15+ pack years Opportunistic assessment - Spirometry for all patients with regular cough, sputum and recurrent winter bronchitis

## General management for all patients with COPD

- Smoking cessation
- Assess for pulmonary rehabilitation & encourage activity
- Review of inhaler technique

Step 2a— Persistent symptoms in the

absence of exacerbations [More symptoms - CAT> 10 & MRC 3-5]

30 dose inhaler £32.50

60 dose inhaler £32.50

daily

First line: LABA/LAMA Combination

Anoro Ellipta 55/22mcg 1 dose daily

Spiolto Respimat 2.5/2.5mcg 2 doses

- Pneumococcal vaccination and annual influenza Dietary Advice BMI<20 or BMI>30 vaccination
- Self management plan
- Psychosocial assessment

levels

• COPD Assessment Test (CAT) Score MRC and exacerbation history

All eco-friendly inhalers have been marked with the symbol:



Step 1 [less symptoms -CAT<10 & MRC 1-2 and low risk of exacerbation]

First line: SABA, assess response after 4 weeks

• Salamol® 100mcg MDI 1-2 doses prn + spacer 200 dose inhaler £1.50



• Salbutamol 100mcg Easyhaler 2 doses prn



200 dose inhaler £3.31



+ spacer

200 dose inhaler £5.56



 Have clinician confirmed exacerbations of COPD

or PEF (20%) or elevated eosinophil

substantial variation in FEV<sub>1</sub> (>400mls)

Step 2b— If still symptomatic before adding an inhaled corticosteroid stop and

reconsider diagnosis, comorbidities,

confirmed diagnosis of COPD and: Have asthmatic features such as

Consider ICS/LABA for patients with a

adherence, inhaler technique

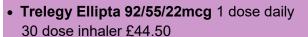
Remember to counsel the patient about the higher risk of pneumonia and document in the patients medical record.

Fostair 100/6mcg MDI 2 doses BD 120 dose inhaler £29.32



**Step 3—** > 2 exacerbations & >1 admission in the past year despite adherence to LABA/LAMA

Assess response after 12 weeks, if no benefit stop ICS and revert back to LABA/LAMA



• Trimbow pMDI 87/5/9mcg 2 doses BD + spacer 120 doses inhaler £44.50



Fostair NEXThaler 100/6mcg 2 doses BD 120 dose inhaler £29.32





Relvar Ellipta 92/22mcg 1 dose OD

30 dose inhaler £22.00





SABAs may be continued at all stages of the pathway. Consider mucolytic (NACSYS or Carbocisteine) for productive cough. Stop/switch after 4 weeks if ineffective

## Is it COPD? Is it asthma?

A diagnosis of asthma may be suspected if the patient has:

- Variable symptoms
- Exceptional clinical response to bronchodilators (>400mls increase in FEV₁)
- A history of wheeze pre-dating 20 pack years

### Patient review

- FEV<sub>1</sub> >50% MRC 1-3 at least annually
- FEV<sub>1</sub> -50-30% MRC 2-5 at least twice a year
- FEV<sub>1</sub> <30% and/or MRC score 3-5 at least four times a year

#### At each review assess:

- Spirometry
- Inhaler technique Aim for all system (be either DPI or pMDI)
- Check inspiratory flow fits the device prescribed
- Consider withdrawal of ICS and document reason for continuation
- Oxygen saturation levels refer if <92% when clinically stable
- Smoking status and desire to quit

- Anxiety and depression
- BMI
- devices to have the same delivery Concordance and understanding of medication
  - MRC scale/CAT
  - Coping mechanisms of patient and carer
  - · Access to benefits
  - Consider referral for pulmonary rehabilitation (MRC 3-5). Patient must be motivated to attend

## Self management plans

Give to all COPD patients – include:

- · Exacerbation recognition and management
- · List of respiratory medication
- Contact number for respiratory nurse
- Smoking status including pack years

- Target oxygen saturation
- Encourage home/gym based exercise MRC 1-2 and pulmonary rehabilitation MRC 3-5
- Follow as per COPD Template (S1 or EMIS)





Vale of York Harrogate and District York Teaching Hospital

# Specialist referral

Refer to Respiratory Team for:

- Consideration for Pulmonary Rehabilitation
- Uncontrolled symptoms despite optimum treatment
- Frequent admissions and co-morbidities (Cor Pulmonale)
- Referral for nebuliser trial/home oxygen
- Diagnostic uncertainty
- · Assessment for lung surgery
- Rapid decline in FEV<sub>1</sub>
- Azithromycin prescribed by Respiratory Specialist only

## Palliative care

Would you be surprised if this patient died in the next year from COPD?

If the answer is no then:

- Offer end of life discussion with patient and family including DNACPR
- Consider Gold Standards Framework
- Discuss Preferred Priorities for care
- Consider fan therapy/opiates/benzodiazepines for symptom relief
- Consider referral to specialist palliative care team

## Remember

- Prescribing by brand names is recommended to ensure consistent supply of inhaler device
- This describes a pragmatic and simplified approach to COPD management
- The preferred therapies listed are based on
  - Ease of use of inhaler device
  - · Clinical trial data of safety and efficacy
  - Cost
- Consideration of switching to lower carbon inhalers https://www.nice.org.uk/guidance/ng115

North Yorkshire CCG and Vale of York CCG COPD Pathway Approved: September 2020 | Version 1.1