NORTHUMBERLAND AND NORTH TYNESIDE GUIDELINES FOR:

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Approved: October 2015

Review date: October 2017

This guideline has been prepared and approved for used within Northumberland CCG, North Tyneside CCG and Northumbria Healthcare NHS FT

Guideline development group and declarations of interest

Name	Title	Declaration of interest
Dr Gbenga Afolabi	Respiratory Physician and Interim Deputy Medical Director, Northumbria Healthcare NHS FT	None
Dr Stephen Bourke	Respiratory Physician, Northumbria Healthcare NHS FT	Industry sponsored research and conference attendances
Dr Alice Melville	Respiratory Physician, Northumbria Healthcare NHS FT	Industry sponsored conference attendances
Dr Frances Naylor	Director of Blyth Valley and Long Term Conditions, Northumberland CCG	None
Mrs Helen Seymour	Senior Medicines Optimisation Pharmacist, North of England Commissioning Support Unit	None
Dr Caroline Sprake	Long term conditions lead for North Tyneside CCG and Chair of North of Tyne Respiratory network	None

Approved by:

Committee	Date
North of Tyne Medicines Guideline and Use Group	12/10/15
North of Tyne Area Prescribing Committee	13/10/15

This guideline has been developed by clinicians working in primary and secondary care to aid the implementation of the NICE Chronic Obstructive Pulmonary Disease guideline (CG12). This guideline simplifies the NICE guideline and emphasises the need for reassessing diagnosis and checking the patient's inhaler technique and concordance at each visit and before intensifying treatment. Further the guide gives advice about which formulary approved inhalers should be used within each class of inhaler including the use of LABA/LAMA inhalers which were not licensed at the time of NICE guideline publication.

This guideline is not exhaustive and does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

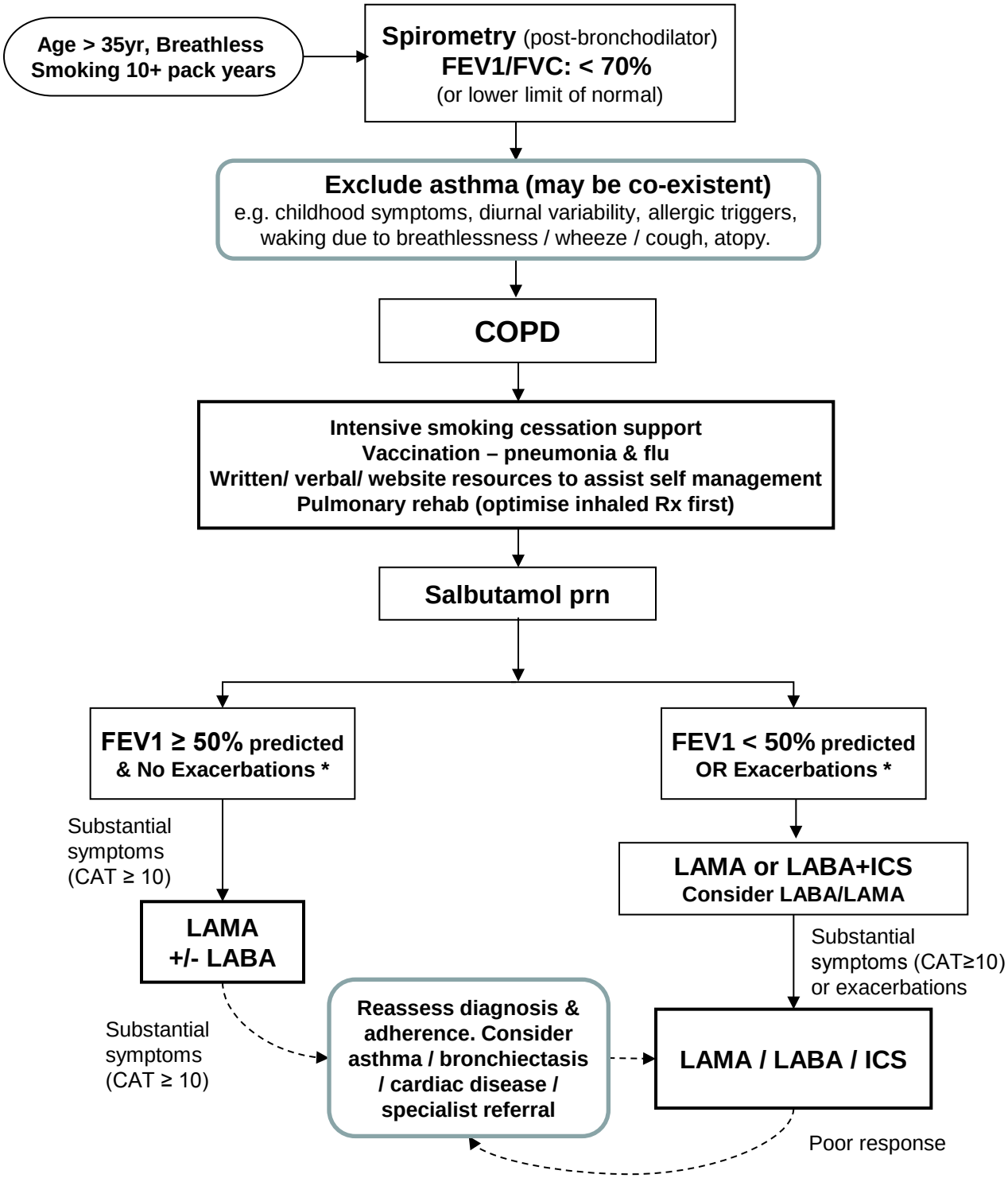
Full details of contra-indications and cautions for individual drugs are available in the BNF or in the Summary of Product Characteristics (available in the Electronic Medicines Compendium) www.emc.medicines.org.uk

An electronic version of this document can also be viewed / downloaded from the North of Tyne Medicines Optimisation Website at http://medicines.necsu.nhs.uk/guidelines/north-of-tyne-guidelines/

North Tyneside CCG, Northumberland CCG, Northumbria Healthcare NHS Trust

COPD Treatment Guide

October 2015

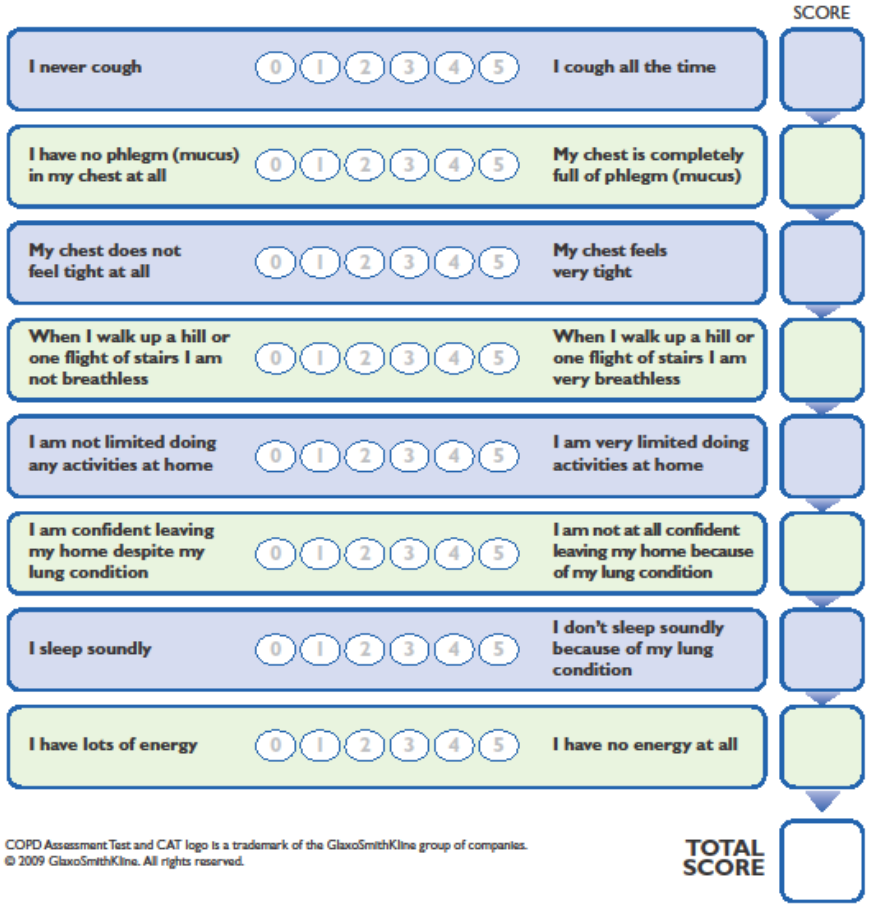


*** Exacerbation history**: ≥ 2 clinically verified exacerbations in the past two years.

- Diagnosis depends on clinical history and quality assured spirometry.
- New persistent or red flag symptoms – consider chest Xray (lung cancer?).
- Check inhaler technique and concordance at each visit & before intensifying treatment. The least cost-effective inhaler is the one the patient cannot, or does not, use. E-learning for health care professionals available here. Shared decision making here.
- Monitor oxygen saturation: oxygen assessment if SpO2 <92% at rest or de-saturation on exercise.
- Screen for anxiety and depression (risk adverse outcome – consider health psychology).
- ICS (notably fluticasone) is associated with increased risk of pneumonia. Consider low risk ICS (budesonide)/LABA combination or LABA/LAMA, especially if recurrent pneumonia.

See second page for further information.

How is your COPD? Take the COPD Assessment Test TM



Grade	Degree of breathlessness related to activities – eMRCD
1	Only breathless on strenuous exertion
2	Breathless hurrying on the level or walking up a slight hill
3	Walks slower than contemporaries, or stops after walking on the level for 15 minutes
4	Stops for breath after walking about 100 meters, or for a few minutes, on the level
5a	Too breathless to leave the house unassisted but independent in washing and / or dressing
5b	Too breathless to leave the house unassisted and requires help with washing and dressing

October 2015

To diagnose COPD: clinical history **and** post bronchodilator spirometry showing FEV1/(F)VC <70% (or Lower Limit of Normal). Perform a CXR at diagnosis (if none within 12 months) looking for evidence of other pathology, including malignancy.

Spirometry must be performed by a trained individual who maintains competency. Spirometers need to be maintained and calibrated regularly to ensure accuracy.

Severity & monitoring of COPD: use FEV1 %predicted (actual FEV1/expected FEV1), exacerbation history & symptoms to assess severity, then follow treatment guide.

Intensive Smoking Cessation support: stopping smoking is the most important intervention in COPD.

Pulmonary Rehabilitation: improves exercise tolerance and reduces hospital bed days by 50%. Offer to patients with MRC 3-5. Consider early after an exacerbation. Other COPD patients should be offered referral to exercise schemes.

Weight: Consider referral to community dietitians if BMI<20 or unintentional weight loss. Consider weight reduction in the obese (BMI >30).

INHALERS – device led inhaler choice (http://www.northoftyneapc.nhs.uk/wp-content/uploads/sites/6/2012/03/North-of-Tyne-APC-Fomulary-Inhalers.pdf)**. Check inhaler technique and concordance at each appointment and before treatment intensification.**

- SABA – 1st line – salbutamol, 2nd line – terbutaline. Nebulisers do not offer convincing advantages over metered dose inhalers given via a spacer device and are not routinely recommended.
- LAMA –tiotropium (Spiriva®) or aclidinium (Eklira Genuair®: side effects such as dry mouth less common, better nighttime control.
- LAMA/LABA – 1st line – Aclidinium bromide/formoterol fumarate dehydrate (Duaklir Genuair®), 2nd line – vilanterol trifenatate/umeclidinium bromide (Anoro Ellipta®), 3rd line – indacaterol maleate/glycopyrronium (Ultibro breezhaler®)
- LABA / ICS – 1st line – budesonide/formoterol fumarate dehydrate (Duoresp®, Symbicort®), 2nd line Relvar Ellipta®.

Mucolytics: mucolytic therapy may improve cough and difficulty expectorating and may reduce exacerbation frequency. A trial period of 4-6 weeks is recommended in patients with chronic productive cough or frequent exacerbations.

Exacerbations: Prednisolone 30mg/day (5 days) + antibiotics (5 days) if increase in any 2 of: breathlessness, sputum volume, sputum purulence.

Antibiotic choice: 1st line: Doxycycline (or Amoxicillin), 2nd line: Co-amoxiclav. In appropriate patients rescue packs have a place. If started patient should contact GP/Nurse within 48 hours. Frequent rescue packs should prompt review, consider specialist review.

CoMorbidities: Approx 40% will have comorbidities such as CVD. Ensure they are assessed & treated.