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**Medicines Management of Chronic Obstructive Pulmonary Disease (COPD) in persons over 16.**

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| Written by: Jemma Clark (Lead Pharmacist for Respiratory Medicine BSUH), Sephora Shaw (Brighton and Hove CCG), Georgina Wingfield (Senior Practice Pharmacist, Benfield Valley Healthcare Hub) & Jo Congleton (Consultant in Integrated Respiratory Care BSUH/SCT)  Reviewed by: : Jemma Clark (Lead Pharmacist for Respiratory Medicine BSUH), Jo Congleton (Consultant in Integrated Respiratory Care BSUH/SCT) & Stacey Nelson (Brighton and Hove CCG) | Approved APC: June 2017 | Date for Review: June 2018 |
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**Medicines Management of Chronic Obstructive Pulmonary Disease (COPD)**

* Offer a one-off pneumococcal vaccination (PPV23) and annual influenza vaccination.1
* Ask about smoking and offer brief advice. If ready, refer to [smoking cessation](https://nww.bsuh.nhs.uk/clinical/teams-and-departments/smoking-cessation/smoking-cessation-referral-form-for-all-patients/) service.2
* Patients who are symptomatic with MRC ≥2 should be offered **pulmonary rehabilitation**. If suitable refer to **community respiratory service.**
* All patients should be asked to demonstrate their **inhaler technique** regularly and **adherence** established before stepping up therapy.
* All patients should have a written **self-management plan** and instructions for/access to a **rescue pack** if appropriate.
* If the patient has a history of asthma alongside COPD (ACO), please refer to [GOLD treatment guideline](https://goldcopd.org/asthma-copd-asthma-copd-overlap-syndrome/).3
* If your patient is on triple therapy LAMA/LABA/ICS consider if this is indicated. ICS is only indicated for frequent exacerbations after non-pharmacological measures have been optimised or patients who have a dual diagnosis of asthma. ICS are associated with increased risk of pneumonia so consider a step down and stop approach to minimise risk*.*

*Step up if persistently breathless and/or frequent exacerbations*

**SABA + LABA/LAMA or LABA/ICS**

*First Line LABA/LAMA: Spiolto Respimat®*

*First Line: LABA/ICS: Fostair® 100 / 6*

**Tripe therapy (LAMA + LABA/ ICS)**

**Severe\*\*\* COPD**

**SABA**

*First Line SABA: Salbutamol CFC Free*

100 micrograms/dose (MDI)

**SABA + LAMA/LABA**

*First Line LAMA/LABA: Spiolto Respimat®*

Assess inhaler technique/

Refer to SSS

Assess inhaler technique/

Consider pulmonary rehab/ Refer to SSS

**Patients with FEV1 <50%1 and**

**2 or more exacerbations a year4**

Assess inhaler technique/

Consider pulmonary rehab/ Refer to SSS

**First Line\***

Assess inhaler technique/

Consider pulmonary rehab/ Refer to SSS

**Recurrent exacerbations despite all above measures**

**SABA PRN +**

**Triple therapy: LABA/LAMA + ICS (off label) or LAMA + LABA/ ICS**

Assess inhaler technique/

Consider pulmonary rehab/ Refer to SSS

**SABA + LAMA\*\***

*First Line LAMA: Braltus Zonda® Inhaler*

**SABA +**

**Triple therapy: LABA/LAMA + ICS (off label) OR LAMA + LABA/ICS**

*First Line LABA/LAMA: Spiolto Respimat®**First Line LAMA: Braltus Zonda® Inhaler*

*First Line ICS: Clenil Modulite® CFC Free First Line: LABA/ICS: Fostair® 100 / 6*

**SABA + LAMA**

*First Line LAMA: Braltus Zonda® Inhaler*

+/- mucolytic for copious, thick and difficult to clear sputum. Review 4 weeks after initiation and continue if symptoms improve.

**Carbocisteine 1125mg PO BD, reducing to 750mg PO BD as condition improves.**

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| [Click here](http://www.gp.brightonandhoveccg.nhs.uk/files/joint-formulary-inhalerspdf) to view the formulary options for each medicine class of inhaled therapy. Please select a device most appropriate for your patient. |

\*In ACO ICS/LABA may be first choice.3 \*\*If no symptomatic response to LAMA, review diagnosis, consider trial of LABA before stepping up \*\*\*MRC ≥2 or CAT score ≥10

Abbreviations SABA: Short-acting b2 agonist SAMA: Short-acting antimuscarinic ICS: inhaled corticosteroid LABA: Long-acting b2 agonist

ACO: Asthma-COPD Overlap SSS: Stop smoking service MRC: Medical Research Council Dyspnoea Scale LAMA: Long-acting antimuscarinic

**Managing exacerbations on discharge**

Self-management intervention with communication with a health care professional improves health status, reduces hospitalisation and attendances to emergency admission units.4

Patients should be assessed for suitability of self-management of exacerbations prior to prescribing.

For those patients who are suitable and have been educated to use rescue packs appropriately, prescribe a **short acting bronchodilator** plus **oral** **corticosteroids** and/or **oral antibiotics**.

**Short Acting Bronchodilators:**

Advise patient to increase frequency of short-acting b2 agonist.

1st Line Salbutamol Evohaler dose (100micrograms/dose): 2 puffs INH QDS via aerochamber

Other treatment options:

Nebulised dose: 2.5mg/2.5mL NEB QDS (Only if patient has nebulised therapy)

Salbutamol Easibreathe 100micrograms/dose: 2 puffs INH QDS

Salbutamol Autohaler 100micrograms/dose: 2 puffs INH QDS

Salbutamol Accuhaler 200micrograms/dose: 1 puff INH QDS

Terbutaline Turbuhaler 500micrograms/dose 1 puff INH QDS

**Oral Corticosteroids:**

1st Line Prednisolone 30mg OD for 5 days.

Corticosteroid may be prescribed for up to a maximum of 14 days depending on clinical symptoms.

**Oral Antibiotics:5, 6**

If purulent sputum and increased shortness of breath and/or increased sputum volume treat with antibiotics’;

1st Line Amoxicillin 500mg TDS for 5 days

2nd Line Doxycycline 200mg OD on day 1, then 100mg OD from day 2 to complete 5 day course.

(If penicillin allergy or recent failure to amoxicillin)

Advise patient to seek further medical attention if their symptoms do not begin to improve within 3 days of starting antibiotic, or if symptoms worsen.

Advise patient that if they start their rescue pack, they must contact their GP practice/practice nurse to inform them they are less well and have started the rescue pack. Alternatively patients under the care of the community respiratory service may contact them to inform them they are less well and have started the rescue pack.

Monitor usage of rescue packs and consider referral to the **community respiratory service.**

References

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