### Exacerbation History

<table>
<thead>
<tr>
<th><strong>EXACERBATION HISTORY</strong></th>
<th><strong>SYMPTOMS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>≥2 or ≥1 leading to specialist care</td>
<td>MRC* 1 - 2 CAT &lt;10</td>
</tr>
<tr>
<td>≥2 or ≥1 leading to specialist care</td>
<td>MRC* ≥ 3 CAT ≥ 10</td>
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</tbody>
</table>

#### A: Minimal Exacerbations & High Symptoms

- Start at LAMA and if symptoms persist switch to LAMA/LABA.

#### B: Minimal Exacerbations & High Symptoms

- Start at LAMA and if further exacerbations preferred direction of travel is to start a LAMA/LABA. Consideration can be given to alternative use of LABA/ICS if multiple exacerbations and frequency of these.

#### C: High Exacerbations & Minimal Symptoms

- If a patient is currently controlled on a device not listed there is no need to change.

- Evaluate effect of SABA and continue, stop or try a different class of bronchodilator.

#### D: High Exacerbations & High Symptoms

- Attempt to limit ICS use where appropriate and/or step down where patients’ symptoms and exacerbations are controlled. If patient prescribed LABA/ICS and has persistent symptoms/further exacerbations consider step up to triple therapy.

- Device continuity is key as patient moves through the classes and/or combination of medications.

- Preferred treatment box (at left) outlined in green.

- Start in quadrant A – D (at left) with corresponding symptoms.

- If a patient is currently controlled on a device not listed there is no need to change.

#### Treatments not listed, but included in the Pan Mersey Formulary, may be required.

- Smoking Cessation & Pulmonary Rehabilitation intervention essential at every opportunity

- Inhaler device should take precedent over drug choice within a class.

Acknowledgement: This guideline is based on the principles outlined in GOLD 2018.

### Table of Inhaled Therapies

<table>
<thead>
<tr>
<th><strong>SABA</strong></th>
<th><strong>LAMA</strong></th>
<th><strong>LAMA/LABA</strong></th>
<th><strong>LABA/ICS</strong></th>
<th><strong>TRIPLE (LAMA/LABA/ICS)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salbutamol 100mcg/dose 1-2 puffs as required</td>
<td>Spiriva® Respimat®</td>
<td>SpioIto® Respimat®</td>
<td>Fostair® (Becloametasone 100mcg / Formoterol 6mcg)</td>
<td>Trimbow® (Becloametasone 87mcg / Formoterol 5mcg / Glycopyrroinum 9mcg)</td>
</tr>
<tr>
<td>Easyhaler® Salbutamol 100mcg/dose 1-2 puffs as required</td>
<td>Incruse® Ellipta®</td>
<td>Anoro® Ellipta®</td>
<td>Relvar® Ellipta® 92/22</td>
<td>Trelegy® Ellipta®</td>
</tr>
<tr>
<td>Seebri® Breezhaler®</td>
<td>Ultiro® Breezhaler®</td>
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</tbody>
</table>

Note: MDI = Metered Dose Inhaler; DPI = Dry Powder Inhaler.
Practical Points to Consider During the Consultation:
- Guideline is for primary care management of COPD NOT Asthma COPD Overlap Syndrome.
- Check inhaler technique at every opportunity.
- Consider referral to their usual community pharmacy when changing inhalers for further support for the patient.
- A spacer device should be prescribed for use with Metered Dose Inhalers (MDIs).

Other Treatments:
- **Mucolytic** – Acetylcysteine (NACSYS®), or carbocisteine. Consider only in patients with a chronic productive cough, continue only if improvement in symptoms (reduction cough / sputum). Do not routinely prescribe to prevent exacerbations.
- **Oxygen** – Pulse oximetry is recommended as part of routine COPD reviews. Oxygen saturation <92% should be considered (with other risk factors) for further oxygen assessment to specialist oxygen services.
- **Rescue Pack** – Prescribers should consider a formulary choice antibiotic and oral corticosteroid for patients to self-manage their condition. This allows patients to have a supply at their home to take if they feel themselves starting to exacerbate. Patients should be fully educated to understand triggers and when to use these medications.
- **Oral Corticosteroids (Maintenance Dose)** – Not routinely used. This should only be initiated under specialist advice.
- **Prophylactic Antibiotics** – Initiated by respiratory specialist only, can then be continued in primary care.

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### References:
3. RightBreathe Inhalers.
4. NICE Clinical Guidance 101 – COPD disease ion over 16s; diagnosis and management
5. COPD Assessment Test.
6. Primary Care Respiratory Society UK (PCRS) MRC Dyspnoea Scale