### Exacerbation History

<table>
<thead>
<tr>
<th>Exacerbation History</th>
<th>MRC* 1 - 2</th>
<th>CAT &lt;10</th>
<th>MRC* ≥ 3</th>
<th>CAT ≥10</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥2 or ≥1 leading to specialist care</td>
<td><img src="image.png" alt="Diagram" /></td>
<td><img src="image.png" alt="Diagram" /></td>
<td><img src="image.png" alt="Diagram" /></td>
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<tr>
<td>0 or 1 NOT leading to specialist care</td>
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### Symptoms

- **A** **Minimal Exacerbations & Minimal Symptoms**: Evaluate effect of SABA and continue, stop or try a different class of bronchodilator.
- **B** **Minimal Exacerbations & High Symptoms**: Start at LAMA and if symptoms persist switch to LAMA/LABA.
- **C** **High Exacerbations & Minimal 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.
- **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.

### Treatments

<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® (Tiotropium 2.5mcg) 2 puffs once daily Caution if eGFR&lt;50</td>
<td>Spiolto® Respimat® (Tiotropium 2.5mcg / Olodaterol 2.5mcg) 2 puffs once daily Caution if eGFR&lt;50</td>
<td>Fostair® (Beclometasone 100mcg / Formoterol 6mcg) 2 puffs twice daily FEV1&gt;50% = off label use</td>
<td>Trimbow® (Beclometasone 87mcg / Formoterol 5mcg / Glycopyrronium 9mcg) 2 puffs twice daily Use after LAMA/LABA before LABA/ICS = off label</td>
</tr>
<tr>
<td>Easyhaler® Salbutamol 100mcg/dose 1-2 puffs as required</td>
<td>Incruse® Ellipta® (Umeclidinium 55mcg) 1 puff once daily</td>
<td>Anoro® Ellipta® (Umeclidinium 55mcg / Vilanterol 22mcg) 1 puff once daily</td>
<td>Relvar® Ellipta® 92/22 (Fluticasone 92mcg / Vilanterol 22mcg) 1 puff once daily</td>
<td>Trelegy® Ellipta® (Fluticasone 100mcg / Umeclidinium 62.5mcg / Vilanterol 25mcg) 1 puff once daily Use after LAMA/LABA before LABA/ICS = off label</td>
</tr>
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### Notes

- **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.**

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### Acknowledgement

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

*PCRS values

- MRC* values

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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.

Vaccination:

Influenza vaccination decreases the incidence of lower respiratory tract infections.

Pneumococcal vaccination decreases lower respiratory tract infections. Pneumococcal vaccinations PCV13 and PPSV23 are recommended for all patients ≥65 years of age. The PPSV23 is also recommended for younger COPD patients with significant comorbid conditions including chronic heart disease or lung disease.

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.