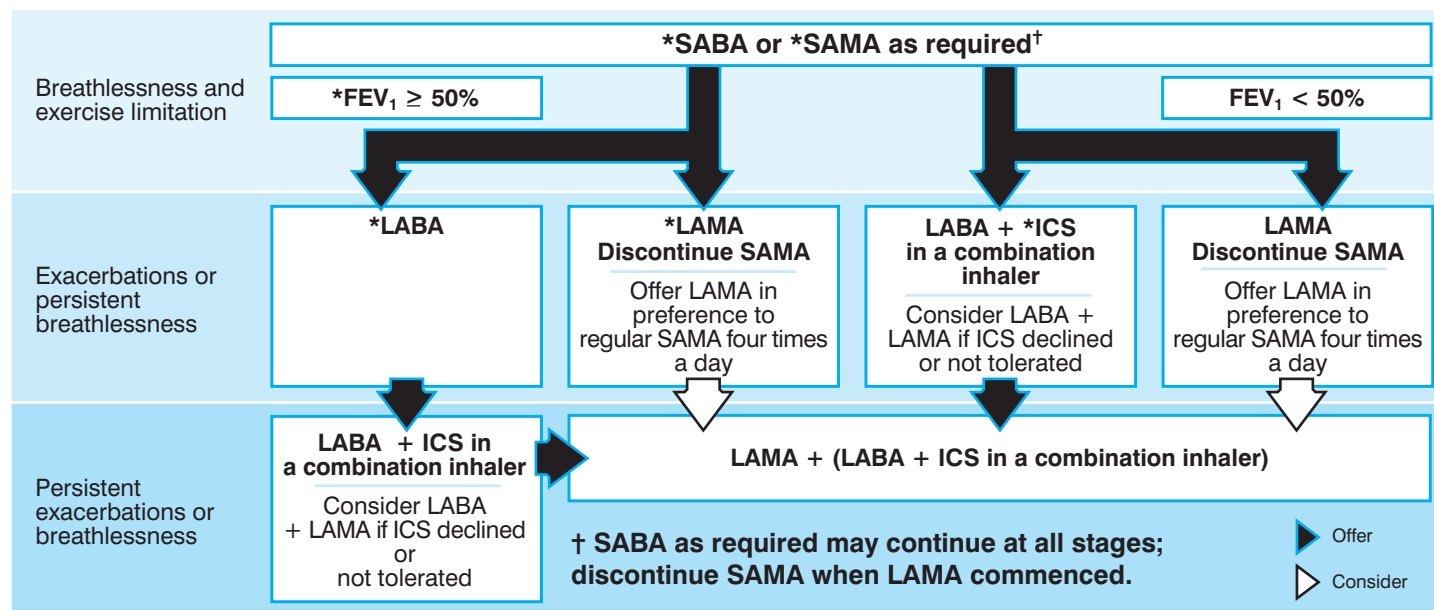


# Wakefield & Kirklees Guidelines for Managing Stable COPD in Primary Care (Wakefield version)

**GENERAL MANAGEMENT FOR ALL PATIENTS WITH COPD**  
 SMOKING CESSATION – ENCOURAGE EXERCISE – REVIEW OF INHALER TECHNIQUE –  
 PNEUMOCOCCAL VACCINATION AND ANNUAL INFLUENZA VACCINATION – RECORD BMI AND MRC DYSPOEA SCORE –  
 ADJUSTED BODE SCORE (USING NUMBER OF HOURS DEDICATED TO WALKING)

**TREATMENT OF BREATHLESSNESS OR EXERCISE LIMITATION**  
 Each addition to therapy should involve a 4 week trial with discontinuation of any components not demonstrating an improvement in breathlessness or exercise limitation. If patient remains symptomatic review inhaler technique, if satisfactory treatment should be intensified by combining therapies following the algorithm below.



### Trial of Theophylline

Theophylline should only be used after a trial of short-acting bronchodilators and long-acting bronchodilators, or in patients who are unable to use inhaled therapy, as there is a need to monitor plasma levels and interactions, including effects of smoking cessation.

The choice of drug(s) should take into account the person's symptomatic response, their preference and ability to manipulate the device, the drug's potential to reduce exacerbations, its side effects and cost.

<p><b>Other considerations</b></p> <ul style="list-style-type: none"> <li>• <b>Mucolytics</b> should not be routinely used to prevent exacerbations in people with stable COPD but may be of use in patients with chronic productive cough. <b>Discontinue if no improvement after 4 weeks</b></li> <li>• Consider use of patient held <b>oral steroids and antibiotics</b> for use with a self management plan for prompt treatment of exacerbations (refer to guideline)</li> <li>• <b>Anxiety and depression</b> should be identified, assessed and treated appropriately</li> <li>• <b>Osteoporosis</b> prophylaxis should be considered in patients requiring frequent courses of oral corticosteroids. The risks of developing osteoporosis should be discussed with patients on high dose ICS (especially in the presence of other risk factors)</li> <li>• Consider referral to the <b>Expert Patient Programme</b></li> </ul>	<p><b>Cautions</b></p> <p>Be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with ICS and be prepared to discuss this with patients</p> <p>***Patients with FEV<sub>1</sub> &lt; 30% treated with inhaled steroids who are diagnosed with pneumonia should have treatment reviewed by a respiratory physician</p>	<p><b>Oxygenation</b></p> <p>Measure saturation by pulse oximetry if FEV<sub>1</sub> &lt; 1.5 litres/40% predicted</p> <p>If oxygen saturation &lt; 92% consider referral to Secondary Care Respiratory Team</p> <p>Refer to NHS Wakefield District Long Term Oxygen Therapy guidance for further information</p> <p><b>Treatments considered unsuitable for COPD</b></p> <ul style="list-style-type: none"> <li>• Routine maintenance with oral corticosteroids is not normally recommended</li> <li>• Prophylactic antibiotics</li> <li>• Alpha-1 antitrypsin replacement therapy</li> <li>• Antioxidant therapies</li> <li>• Antitussive therapy</li> </ul>
	<p><b>Disability</b></p> <p>In view of the magnitude of the benefits of <b>Pulmonary Rehabilitation Programmes</b>, the guidelines recommend that it should be offered to all appropriate patients with COPD managed in primary or secondary care who consider themselves functionally disabled by their disease (usually *MRC grade 3 and above) including those who have had a recent hospitalisation for an exacerbation</p>	

\* = **Abbreviations:** ICS – Inhaled corticosteroid LABA – Long acting beta<sub>2</sub> agonist LAMA – Long acting muscarinic antagonist  
 MRC – Medical Research Council SABA – Short acting beta<sub>2</sub> agonist SAMA – Short acting muscarinic antagonist

# Wakefield & Kirklees Guidelines for Managing Stable COPD in Primary Care (Wakefield version)

## Review in Primary Care:

### Mild/Moderate/ Severe Airflow Obstruction

### Very Severe Airflow Obstruction

#### Frequency

AT LEAST ANNUAL

AT LEAST TWICE PER YEAR

#### Measurements to make

- FEV<sub>1</sub> and \*FVC measurement
- Record \*BMI
- MRC Dyspnoea score

- FEV<sub>1</sub> and FVC measurement
- Record BMI
- MRC Dyspnoea score
- SpO<sub>2</sub>

#### Clinical assessment

- Smoking status and desire to quit
- Adequacy of symptom control
  - Breathlessness
  - Exercise tolerance
  - Estimated exacerbation frequency
- Presence of complications
- Effects of each drug treatment
- Inhaler technique
- Need for referral to specialist and therapy services
- Need for pulmonary rehabilitation
- Consider referral to Expert Patient Programme
- Self management advice
- Measure saturation by pulse oximetry if FEV<sub>1</sub> < 1.5 litres/40% predicted

- Smoking status and desire to quit
- Adequacy of symptom control
  - Breathlessness
  - Exercise tolerance
  - Estimated exacerbation frequency
- Presence of cor pulmonale
- Need for long term oxygen therapy
- Patients nutritional state
- Presence of depression
- Effects of each drug treatment
- Inhaler technique
- Need for social services and occupational therapy unit
- Need for referral to specialist and therapy services
- Need for pulmonary rehabilitation
- Presence of complications
- Consider referral to Expert Patient Programme
- Self management advice
- Consider palliative care requirements

To assess the impact of COPD on the patient's wellbeing and daily life, consider the use of the COPD Assessment Test copies to download available on line at <http://www.catestonline.org>

\* = **Abbreviations**  
BMI – Body Mass Index  
FEV<sub>1</sub> – Forced Expiratory Volume in 1 Second  
FVC – Forced Vital Capacity  
MRC – Medical Research Council  
SpO<sub>2</sub> – Saturation of Peripheral Oxygen (on pulse oximetry)

To assess the impact of COPD on the patient's wellbeing and daily life, consider the use of the COPD Assessment Test copies to download available on line at <http://www.catestonline.org>

For video demonstrations of correct inhaler technique: <http://www.medicines.org.uk/guides/pages/how-to-use-your-inhaler-videos>

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#### References:

Chronic Obstructive Pulmonary Disease, National clinical guidance for management of Chronic Obstructive Pulmonary Disease in adults in primary and secondary care, updated June 2010, NICE  
\*\*\* MHRA Drug Safety Update October 2007 Issue 3

#### Group responsible for development:

NHS Wakefield District Respiratory Partnership Group

#### Developed in collaboration with:

Mid Yorkshire NHS Hospitals Trust and NHS Kirklees