Derbyshire Medicines Management UPDATE

www.derbyshiremedicinesmanagement.nhs.uk

Reviewing COPD – an update on current issues

Derbyshire COPD Guidelines can be found here   Updated: January 2023 Date of review: December 2025

NHS

COPD is predominantly caused by smoking and is a major cause of morbidity and mortality in the UK.

- **Treatment of tobacco addiction & smoking cessation is the only intervention that reduces decline in FEV_1.**
- **Drug treatment is aimed at managing symptoms. No drug is perfect; all have limitations and due to the nature of the disease, patients will deteriorate with time. Achievable targets need to be set and effectiveness of treatment measured against these targets. *If a new treatment does not improve a patient's quality of life, then stop it and try something else; don't keep adding in.***

Management of all COPD patients

- **Pulmonary rehabilitation:** offer to all patients who consider themselves functionally limited by breathlessness or fatigue, including those who have had a recent hospitalisation for an acute exacerbation. Physiotherapist support for breathing techniques. For Southern Derbyshire and Erewash see ImpACT+ for further information. For North Derbyshire see Respiratory & pulmonary therapy service :: Derbyshire Community Health Services (dchs.nhs.uk)
- **Treatment of tobacco addiction & smoking cessation** – Provide the Live Life Better Derbyshire number **0800 0852299** for Derbyshire patients or the Live Well Derby number **01332 641254** for Derby City patients
- Annual Flu vaccination + once only pneumococcal vaccination.
- Advice and support on exercise and nutrition
- Patient information and self-management plan should be offered to assist patients in self care
- Psychological services for anxiety and depression related to COPD. See DCHS Health Psychology Derbyshire (dchs.nhs.uk)
- Social services and occupational therapy for support with activities of daily living.

The online COPD Assessment Test (CAT) may be used, to assess the effectiveness of COPD treatments with improvements in symptoms, activities of daily living, exercise capacity and rapidity of symptom relief, in addition to lung function tests. The CAT assessment questionnaire can be found online.

Ask the patient to give examples - if a treatment is not providing significant benefit, is it worth continuing it?

Before moving to the next stage in the therapeutic management of COPD always check the patient's adherence to treatment and inhaler technique.

Spirometry training – are you able to produce a valid reading? Do you know how to interpret it? Please contact the respiratory team for information on training or see https://www.artp.org.uk/Training.

For patients prescribed new inhalers consider referring to the community pharmacist for the New Medicines Service (NMS); this will help to ensure that the patient gets the full benefit from their new treatment.

Prescribing notes – For further information see JAPC COPD guidelines

LABA + LAMA combinations

- The evidence shows that LABA/LAMA provides the greatest benefit to quality of life in patients with no asthmatic features, is better than other inhaled treatments for many individual outcomes (such as reducing the risk of moderate to severe exacerbations) and is the most cost-effective option.

LABA + ICS combinations

- Most trials exclude patients with a combined diagnosis of COPD and asthma → No direct evidence. NICE recommend LABA/ICS for patients who have asthmatic features/features suggesting steroid responsiveness. NICE do not recommend using "oral corticosteroid reversibility tests" to identify patients who should be prescribed ICS.
- Be vigilant for potential adverse effects with ICS, e.g. pneumonia, anxiety, sleep disorders, behavioural changes, including psychomotor hyperactivity and irritability (predominantly in children), depression, aggression. Patients should be informed of the potential risks.

LABA + LAMA + ICS

- Stronger evidence shows that triple therapy benefits patients with asthmatic features taking LABA/ICS combinations, compared to LABA/LAMA.
- For patients who are taking LABA/ICS **offer** LAMA+LABA+ICS and for patients taking LABA/LAMA **consider** LAMA+LABA+ICS if their day-to-day symptoms continue to adversely impact their quality of life, **or** they have a severe exacerbation (requiring hospitalisation), **or** they have two moderate exacerbations within a year.
- Document the reason for continuing ICS use in clinical records and review at least annually. Consider stepping down treatment with an ICS - see local guidance for further details

Oral corticosteroids- not normally recommended however may be prescribed on specialist recommendation, may require osteoprotection.

Oral prophylactic antibiotic therapy - azithromycin (off label) after respiratory specialist initiation as per shared care guidance.

Theophylline - offer only after inhaler therapy has been optimised. See SPS Drug Monitoring for theophylline.

Mucolytics - for chronic cough productive of sputum, consider N-acetylcysteine (NACSYS) 600mg effervescent tablets OD or carbocisteine capsules /sachets 750mg TDS for 6-8 weeks then 750mg BD if improvement in sputum production and reduction in viscosity. Do not routinely use mucolytic to prevent exacerbations in people with stable COPD. Mucolytic therapy should be stopped if there is no benefit after a 4 week trial.

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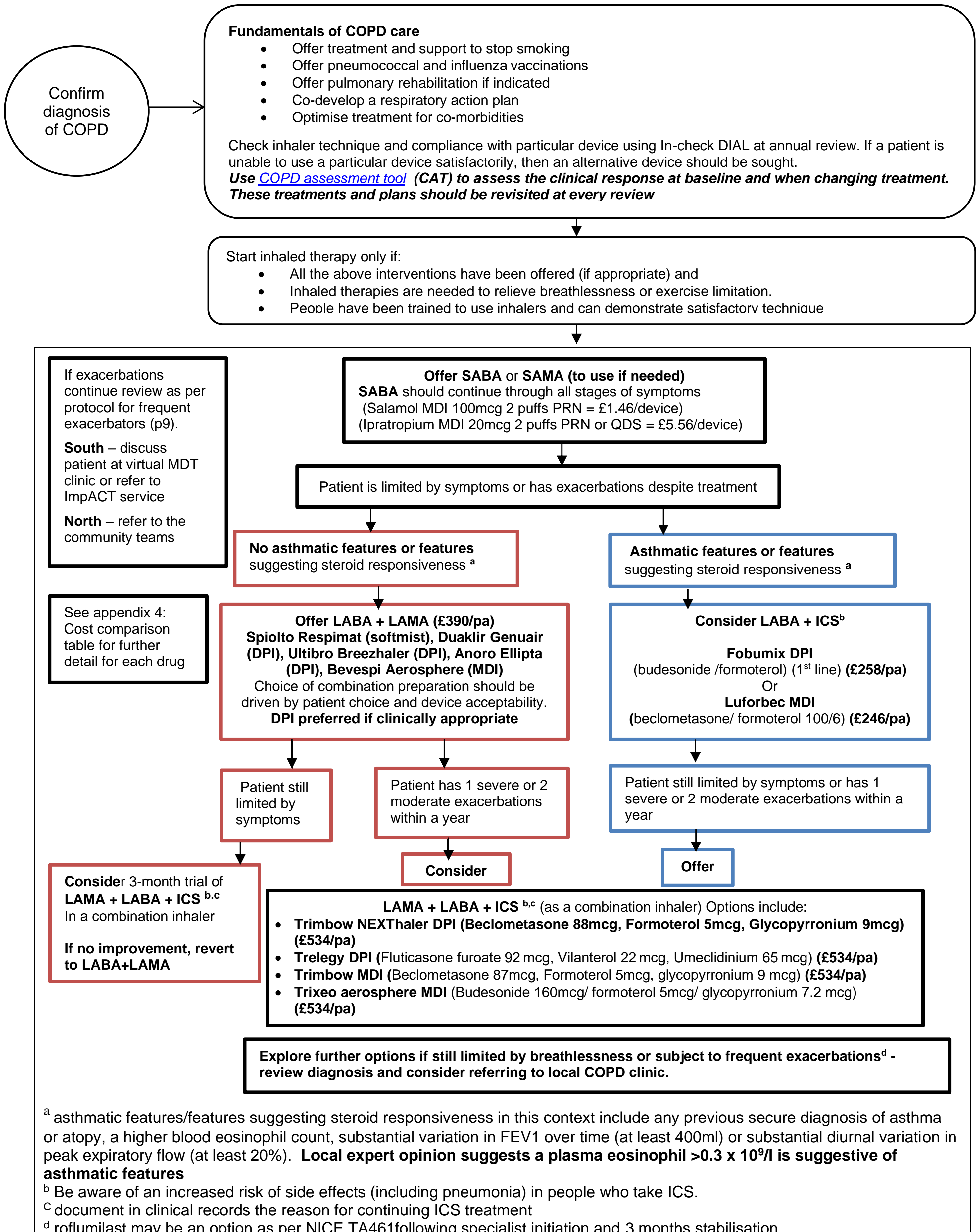
Management of stable COPD



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