TAYSIDE PRESCRIBER

NHS Tayside

Issue 131 – April 2014

Produced by the NHS Tayside Medicines Governance Unit in conjunction with the Respiratory MCN Formulary Group

Respiratory Update - COPD

Use of Inhaled Corticosteroids (ICS) in COPD

Clinicians and prescribers are reminded that ICS are only indicated in the treatment of COPD when:

(i) Post bronchodilator **FEV1 is less than 50%** of the predicted value **and** the patient has one of the following: - **repeated exacerbations** or **persistent breathlessness OR**

(ii) Post bronchodilator **FEV1 is greater than 50%** of the predicted value and patients are symptomatic despite regular use of long-acting bronchodilators

	Symptoms	Inhaled Medication		
Step 1	Breathlessness and exercise limitation	SABA (short acting beta-2 agonist bronchodilator) or SAMA (short acting antimuscarinic bronchodilator) as required		
Step 2	Persistent breathlessness and/or repeated exacerbations	SABA or SAMA as required	+	LABA (long acting beta-2 agonist bronchodilator)
			or	
		SABA as required	+	LAMA (long acting antimuscarinic bronchodilator)
Step 3	Persistent breathlessness and/or repeated exacerbations despite treatment at step 2	SABA as required	+	LABA + LAMA
Step 4	Persistent breathlessness and/or repeated exacerbations despite treatment at step 3	SABA as required	+	Combined ICS and LABA + LAMA

NICE estimate up to 70% of COPD patients in the UK are prescribed inhaled steroids.[1] Some of these patients are gaining little or no benefit from the inhaled steroid while being exposed to considerable risk of unwanted local and systemic effects. These include increased risk of pneumonia and potentially osteoporosis.[2] A relatively low level of prescribing of single component LABA inhalers in Tayside suggests that LABA/ICS combination inhalers are commonly prescribed when the FEV1 is greater than 50% predicted. A change in this prescribing pattern would improve both the safety and cost-effectiveness of prescribing.

Patients should be informed of the potential risks/benefits of ICS in COPD when drugs are initiated and at annual review and ICS treatment stopped if not indicated.*

If ICS/LABA is prescribed for COPD, a licensed product should be used. NHS Tayside formulary choices are:

1st choice Seretide 500 Accuhaler® (twice daily)

2nd choice Symbicort 200/6 or 400/12 Turbohaler® (twice daily)

3rd choice Relvar Ellipta® (92/22 micrograms) (once daily)

NB. Unlicensed use of **Seretide Evohaler®** should only be considered if the patient cannot use any of the 3 above licensed products and with patient consent.

Stopping ICS/LABA in COPD*

If patient non compliant with ICS/LABA combination inhaler, stop immediately and replace with LABA. Otherwise reduce dose of ICS over 4-6 weeks and then replace with LABA. This may require short term additional LABA inhaler prescription to maintain LABA dose whilst reducing ICS/LABA combination.

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Co-existing Asthma and COPD

Asthmatics who smoke can develop fixed airway obstruction and have both Asthma and COPD but still require ICS. In these patients a trial reduction in ICS should be managed slowly and the dose of ICS titrated to the asthma symptoms. These patients may not require "COPD" licensed doses of ICS.

Changes to formulary choices in LAMA and LABA therapies for COPD

The Respiratory Formulary group have reviewed these inhalers on the basis of cost effectiveness and to reduce the types of inhaler device patients may need to use. Tayside Area Formulary choices are:

LAMA

1st choice Glycopyrronium (Seebri Breezhaler®) once daily

2nd choice Aclidinium (Eklira Genuair®) twice daily

3rd choice Tiotropium (Spiriva® HandiHaler®) once daily

LABA

1st choice Indacaterol (Onbrez Breezhaler®) once daily

2nd choice Salmeterol twice daily

3rd choice Formoterol fumarate twice daily

These proposals relate to **new** initiation of inhalers but can also be considered as part of annual COPD review. **Spiriva Respimat® (Tiotropium)** has now been removed from the restricted Specialist Formulary list and can be prescribed when appropriate by prescribers if the patient cannot use other devices.

Before increasing dose or initiating new treatment check compliance with existing therapies and inhaler technique.

"The most cost effective inhaler is the inhaler the patient can and will use"

References

1. Peperell K, Rudolf M, Pearson M, *et al*. General practitioner prescribing habits in asthma/COPD. Asthma in Gen Pract 1997;5:29–30.
2. Global Strategy for Diagnosis, Management and Prevention of COPD (updated 2014). Global Initiative for Chronic Obstructive Lung Disease (GOLD). Accessed via: http://www.goldcopd.org/

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