Asthma and COPD – what’s new?

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July 2013
Ben Creagh-Brown

- Royal Surrey County Hospital Clinic Thursday pm
- Nuffield Hospital, Guildford Clinic Thursday am
- Royal Brompton Hospital, London Asthma clinic
Conflicts of interest

• In the past GSK sponsored me to attend American Thoracic Society conferences.

• I am due to attend the European Respiratory Society Annual Conference, sponsored by Napp.
Overview

• Asthma
  1. Recent guidance
  2. Assessing control
  3. Current treatment options
  4. Newer therapies
  5. Treatments in development
  6. When to refer

• COPD
  1. Recent guidance
  2. Current treatment
  3. Controversies
     1. Spiriva
     2. ICS
     3. Cardiac co-morbidities
  4. Newer therapies
  5. Future therapies

Brief discussion of four cases
Asthma

British Guideline on the Management of Asthma

A national clinical guideline

May 2008

Revised January 2012

Updated 2012

www.brit-thoracic.org.uk/

www.ginasthma.org/
Quality standard for asthma

Issued: February 2013

NICE quality standard 25

guidance.nice.org.uk/qs25

An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England


http://guidance.nice.org.uk/QS25
Still a problem

• 5.4 million people are on treatment for asthma in the UK

• National variability - 5-fold difference between PCT areas in the number of emergency admissions in adults

• International variability - Premature mortality from asthma was 1.5 times as high in the UK than in the rest of Europe in 2008 (~1000/yr, 90% considered preventable)
What are we aiming for with asthma control?

The goal of management is for people to be free from symptoms and able to lead a normal, active life.

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### A. Assessment of current clinical control (preferably over 4 weeks)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Controlled (All of the following)</th>
<th>Partly Controlled (Any measure presented)</th>
<th>Uncontrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime symptoms</td>
<td>None (twice or less/week)</td>
<td>More than twice/week</td>
<td>Three or more features of partly controlled asthma*†</td>
</tr>
<tr>
<td>Limitation of activities</td>
<td>None</td>
<td>Any</td>
<td></td>
</tr>
<tr>
<td>Nocturnal symptoms/awaking</td>
<td>None</td>
<td>Any</td>
<td></td>
</tr>
<tr>
<td>Need for reliever/rescue inhaler</td>
<td>None (twice or less/week)</td>
<td>More than twice/week</td>
<td></td>
</tr>
<tr>
<td>Lung function (PEF or FEV₁)‡</td>
<td>Normal</td>
<td>&lt; 80% predicted or personal best (if known)</td>
<td></td>
</tr>
</tbody>
</table>
Asthma education. Environmental control.
(If step-up treatment is being considered for poor symptom control, first check inhaler technique, check adherence, and confirm symptoms are due to asthma.)

<table>
<thead>
<tr>
<th>Controller options***</th>
<th>As needed rapid-acting ( \beta_2 )-agonist</th>
<th>As needed rapid-acting ( \beta_2 )-agonist</th>
<th>To Step 3 treatment, select one or more</th>
<th>To Step 4 treatment, add either</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-dose inhaled ICS*</td>
<td>Select one</td>
<td>Low-dose ICS plus long-acting ( \beta_2 )-agonist</td>
<td>Medium-or high-dose ICS plus long-acting ( \beta_2 )-agonist</td>
<td>Oral glucocorticosteroid (lowest dose)</td>
</tr>
<tr>
<td>Leukotriene modifier**</td>
<td>Medium-or high-dose ICS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Low-dose ICS plus leukotriene modifier</td>
<td>Leukotriene modifier</td>
<td>Anti-IgE treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low-dose ICS plus sustained release theophylline</td>
<td>Sustained release theophylline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Step-up to gain control
- Step-down...
Why step-down?

- Dose-response curve means benefits of increased ICS dose may be minimal
- Side-effects – dysphonia, candida, purpura, skin thinning – dose response ≥400mcg/day
- Adrenal suppression ≥800mcg/day
- Osteoporosis occurs ≥800mcg/day
- Cost...

Cost of over-treatment...

- Symbicort 400/12 ii bd: £76
- Seretide 250 ii bd: £59
- Flutiform 250 ii bd: £46

- Symbicort 200/6 ii bd: £38
- Seretide 125 ii bd: £35
- Flutiform 125 ii bd: £29

- Symbicort 200/6 i bd: £19
- Seretide 50 ii bd: £18
- Flutiform 50 ii bd: £18
Is it safe to step-down?

• RCT Scotland: 259 adult asthmatics, ≥800mcg
• Well controlled step down vs. sham step down
• No difference in exacerbation rates

Adopting a stepdown approach to the use of high dose corticosteroids in patients with chronic stable asthma can lead to a significant reduction in the daily dose of inhaled corticosteroids without compromising asthma control

Hawkins et al. BMJ 2003;326:1115
Assessing asthma control

Clinicians frequently over-estimate asthma control and under-estimate the impact of asthma on patents’ lives

• Ask the patient
  – Unstructured – how are you?
  – Structured: RCP3, ACQ, ACT
• Measure PEF/FEV1
• FeNO
• Inhaler usage

Prim Care Resp J 2009; 18(2): 83-88
RCP 3 questions – assess asthma control

1. Have you had difficulty sleeping because of asthma symptoms (including cough)?
2. Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
3. Has your asthma interfered with your usual activities (e.g. housework work, school, etc)?
Titrating the dose of ICS

Comparison of Physician-, Biomarker-, and Symptom-Based Strategies for Adjustment of Inhaled Corticosteroid Therapy in Adults With Asthma

The BASALT Randomized Controlled Trial
BASALT

• 342 pts with mild-moderate asthma
• Randomised to 3 groups: (9 months)
  – symptom-based adjustment (SBA) of inhaled corticosteroids
  – biomarker-based adjustment (BBA) FeNO
  – physician assessment–based adjustment (PABA) based on NHLI guidelines
• primary outcome was time to first treatment failure, a clinically important worsening of asthma
• Neither PABA nor BBA were superior to SBA

Newer treatments for asthma

- Using symbicort - SMART
- Fostair (MART)
- Flutiform
- Xolair (Omalizumab)
Symbicort SMART
(budesonide/formoterol)

• “In selected adult patients at step 3 who are poorly controlled or in selected adult patients at step 2, the use of budesonide/formoterol in a single inhaler as rescue medication instead of a short-acting β2 agonist, in addition to its regular use as controller therapy has been shown to be an effective treatment regime.”
Symbicort SMART

Pro
• Convenient
• May offer lower ICS dosing, fewer exacerbations and fewer hospital admissions

Con
• May not adequately suppress airway inflammation
• Concerns about the supporting evidence
• Requires good patient understanding
• Associated with poor control in trials (17%)
Fostair

- Beclomethasone/Formoterol
- 100mcg/6mcg
- 100mcg = 200-250mcg BDP equivalent (extrafine)
- 1-2 puffs BD, or 1-2 puffs BD and PRN (MART)
- Cheaper (£29) than Seretide (£35-£60)
- RCT evidence of non-inferiority

Fostair vs Seretide

Fostair vs Symbicort
Flutiform

• Fluticasone/Formoterol
  – 50/5 mcg (£18)
  – 125/5 mcg
  – 250/10 mcg (£46)
• 2 puffs BD
• RCT evidence of non-inferiority

Flutiform vs Seretide
Flutiform vs Symbicort

BMC Pulm Med 2011;11:28
ERS abstract; 2011 Sep 24 - 28
Asthma treatments in development

• Combination inhalers
  – Once daily LABA/ICS (Vilanterol/Fluticasone Fumarate) **Relvar** Q3/2013, DPI by GSK
  – Generic **symbicort** (budesonide/formoterol)

• Novel inhaled therapies
  • Pitrakinra, anti IL-4 and IL-13

• Novel biologics
  – lebrikizumab, anti IL-13
  – mepolizumab, anti IL-5
  – reslizumab, anti IL-5
  – masitinib, anti-mast cell, tyrosine kinase inhibitor
  – OX 914, PDE4 inhibitor

http://www.ukmi.nhs.uk/applications/NDO/
When to refer

- Diagnosis unclear
- Unexpected clinical findings (ie crackles, clubbing, cyanosis, cardiac disease)
- Unexplained restrictive spirometry
- Suspected occupational asthma
- Persistent non-variable breathlessness
- Monophonic wheeze or stridor
- Prominent systemic features (myalgia, fever, weight loss)
- Chronic sputum production
- CXR shadowing
- Marked blood eosinophilia (>1 x 10⁹/l)
- Poor response to asthma treatment
- Severe asthma exacerbation

Requiring frequent OCS
### Differential Diagnosis: COPD and Asthma

<table>
<thead>
<tr>
<th>COPD</th>
<th>ASTHMA</th>
</tr>
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<tbody>
<tr>
<td>Onset in mid-life</td>
<td>Onset early in life (often childhood)</td>
</tr>
<tr>
<td>Symptoms slowly progressive</td>
<td>Symptoms vary from day to day</td>
</tr>
<tr>
<td>Long smoking history</td>
<td>Symptoms worse at night/early morning</td>
</tr>
<tr>
<td></td>
<td>Allergy, rhinitis, and/or eczema also present</td>
</tr>
<tr>
<td></td>
<td>Family history of asthma</td>
</tr>
</tbody>
</table>
COPD
Often treated like this:

1. SABA
2. (LABA)
3. LABA/ICS or LAMA
4. LABA/ICS and LAMA
5. + adjuncts theophylline / carbocysteine / antibiotics / OCS

Simple but likely excessive use of ICS

(NB: OCS not normally recommended)
BTS/NICE 2010

In people with stable COPD who remain breathless or have exacerbations despite use of short-acting bronchodilators as required, offer the following as maintenance therapy:

• if FEV$_1 \geq$ 50% predicted: either LABA or LAMA
• if FEV$_1 <$ 50% predicted: either LABA/ICS, or LAMA
GOLD 2013 added even more

<table>
<thead>
<tr>
<th>Patient Category C</th>
<th>Patient Category D</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH RISK, LESS SYMPTOMS</td>
<td>HIGH RISK, MORE SYMPTOMS</td>
</tr>
<tr>
<td>GOLD 3 or 4</td>
<td>GOLD 3 or 4</td>
</tr>
<tr>
<td>Exacerbations ≥2/yr</td>
<td>Exacerbations ≥2/yr</td>
</tr>
<tr>
<td>mMRC 0-1</td>
<td>mMRC ≥2</td>
</tr>
<tr>
<td>CAT score &lt;10</td>
<td>CAT score ≥10</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Category A</th>
<th>Patient Category B</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW RISK, LESS SYMPTOMS</td>
<td>LOW RISK, MORE SYMPTOMS</td>
</tr>
<tr>
<td>GOLD 1 or 2</td>
<td>GOLD 1 or 2</td>
</tr>
<tr>
<td>Exacerbations ≤1/yr</td>
<td>Exacerbations ≤1/yr</td>
</tr>
<tr>
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<td>mMRC ≥2</td>
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</table>
In patients with FEV$_1$/FVC < 0.70:

<table>
<thead>
<tr>
<th>GOLD 1: Mild</th>
<th>FEV$_1$ ≥ 80% predicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOLD 2: Moderate</td>
<td>50% ≤ FEV$_1$ &lt; 80% predicted</td>
</tr>
<tr>
<td>GOLD 3: Severe</td>
<td>30% ≤ FEV$_1$ &lt; 50% predicted</td>
</tr>
<tr>
<td>GOLD 4: Very Severe</td>
<td>FEV$_1$ &lt; 30% predicted</td>
</tr>
</tbody>
</table>

PLEASE TICK IN THE BOX THAT APPLIES TO YOU (ONE BOX ONLY)

- mMRC Grade 0. I only get breathless with strenuous exercise. ❑
- mMRC Grade 1. I get short of breath when hurrying on the level or walking up a slight hill. ❑
- mMRC Grade 2. I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level. ❑
- mMRC Grade 3. I stop for breath after walking about 100 meters or after a few minutes on the level. ❑
- mMRC Grade 4. I am too breathless to leave the house or I am breathless when dressing or undressing. ❑
Score 0 - 40

I never cough 0 1 2 3 4 5 I cough all the time

I have no phlegm (mucus) in my chest at all 0 1 2 3 4 5 My chest is full of phlegm (mucus)

My chest does not feel tight at all 0 1 2 3 4 5 My chest feels very tight

When I walk up a hill or one flight of stairs I am not breathless 0 1 2 3 4 5 When I walk up a hill or one flight of stairs I am very breathless

I am not limited doing any activities at home 0 1 2 3 4 5 I am very limited doing activities at home

I am confident leaving my home despite my lung condition 0 1 2 3 4 5 I am not at all confident leaving my home because of my lung condition

I sleep soundly 0 1 2 3 4 5 I don't sleep soundly because of my lung condition

I have lots of energy 0 1 2 3 4 5 I have no energy at all

CLICK TO GET YOUR TOTAL SCORE!

www.catestonline.co.uk/
In patients with FEV₁/FVC < 0.70:

| GOLD 1: Mild | FEV₁ ≥ 80% predicted |
| GOLD 2: Moderate | 50% ≤ FEV₁ < 80% predicted |
| GOLD 3: Severe | 30% ≤ FEV₁ < 50% predicted |
| GOLD 4: Very Severe | FEV₁ < 30% predicted |

Please tick the box that applies to you (one box only):

- mMRC Grade 0. I only get breathless with strenuous exercise.
- mMRC Grade 1. I get short of breath when hurrying on the level or walking up a slight hill.
- mMRC Grade 2. I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.
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- mMRC Grade 4. I am too breathless to leave the house or I am breathless when dressing or undressing.

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<thead>
<tr>
<th>Patient Category A</th>
<th>LOW RISK</th>
<th>LESS SYMPTOMS</th>
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<tbody>
<tr>
<td>GOLD</td>
<td>1 or 2</td>
<td></td>
</tr>
<tr>
<td>Exacerbations</td>
<td>≤1/yr</td>
<td></td>
</tr>
<tr>
<td>mMRC</td>
<td>0-1</td>
<td></td>
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<tr>
<td>CAT score</td>
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<table>
<thead>
<tr>
<th>Patient Category B</th>
<th>LOW RISK</th>
<th>MORE SYMPTOMS</th>
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<tbody>
<tr>
<td>GOLD</td>
<td>1 or 2</td>
<td></td>
</tr>
<tr>
<td>Exacerbations</td>
<td>≤1/yr</td>
<td></td>
</tr>
<tr>
<td>mMRC</td>
<td>0-1</td>
<td></td>
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<tr>
<td>CAT score</td>
<td>≥10</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Category C</th>
<th>HIGH RISK, LESS SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOLD</td>
<td>3 or 4</td>
</tr>
<tr>
<td>Exacerbations</td>
<td>≥2/yr</td>
</tr>
<tr>
<td>mMRC</td>
<td>0-1</td>
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<td>CAT score</td>
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<thead>
<tr>
<th>Patient Category D</th>
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<th>MORE SYMPTOMS</th>
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<tbody>
<tr>
<td>GOLD</td>
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<tr>
<td>Exacerbations</td>
<td>≥2/yr</td>
<td></td>
</tr>
<tr>
<td>mMRC</td>
<td>≥2</td>
<td></td>
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<td>CAT score</td>
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<tr>
<td>Patient group</td>
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<td>---------------</td>
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</tr>
<tr>
<td>A Low risk</td>
<td>Short-acting anticholinergic prn or</td>
<td></td>
</tr>
<tr>
<td>Less symptoms</td>
<td>Short-acting β₂-agonist prn</td>
<td></td>
</tr>
<tr>
<td>B Low risk</td>
<td>Long-acting anticholinergic or</td>
<td></td>
</tr>
<tr>
<td>More symptoms</td>
<td>Long-acting β₂-agonist</td>
<td></td>
</tr>
<tr>
<td>C Higher risk</td>
<td>Inhaled corticosteroid + long-acting β₂-agonist</td>
<td></td>
</tr>
<tr>
<td>Less symptoms</td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-acting anticholinergic</td>
<td></td>
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<td></td>
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<tr>
<td>More symptoms</td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-acting anticholinergic</td>
<td></td>
</tr>
</tbody>
</table>
Important non-inhaled interventions

• Smoking cessation
• Pulmonary rehabilitation; promotion of exercise
• Vaccines
• Self-management plans; with spare ABx/Steroids for IECOPD
• Oxygen alerts / Steroid cards
• Treat cardiac co-morbidities
Current controversies

1. Tiotropium may be harmful, particularly the respimat
2. ICS are probably overused, may be associated with harm
3. Cardiac co-morbidities and their treatment
Spiriva/tiotropium and risk of harm

- 2008 FDA warning following MA of 29 RCTs showing increased mortality.
- UPLIFT study (largest single RCT) showed no such increased risk, but excluded those at high CV risk.
- 2011 SR/MA of all Respimat COPD studies – 50% increased CV death.
- Others corroborate these findings.
- “Level 1 scientific evidence that tiotropium Respimat increases the risk of cardiovascular and all-cause mortality”.

http://thorax.bmj.com/content/68/1/5
Excessive use of ICS in COPD

- Guideline recommendations for the use of ICS in COPD are largely based on their preventive effect on exacerbations – although evidence is mixed
- No evidence of improved mortality; limited evidence of slowing FEV$_1$ decline; insignificant improvement in HRQoL
- Main risk – 70% increase in the rate of hospitalisation for pneumonia.
- “The indiscriminate use of ICS in COPD may expose patients to an unnecessary increase in the risk of side-effects such as pneumonia, osteoporosis, diabetes and cataracts, while wasting healthcare spending and potentially diverting attention from other more appropriate forms of management such as pulmonary rehabilitation and maximal bronchodilator use.”
Cardiac co-morbidities and COPD

• Commonly co-exist with COPD: IHD, AF, HT and heart failure
• Treatment including beta-blockers should be the same (β-1 selective: atenolol, bisoprolol, metoprolol, nebivolol) but often isn’t (BNF)
• CV death is the commonest cause of death in COPD and potentially treating co-morbidities will improve prognosis more than any COPD treatment!
• Evidence of benefit of β-B in outcome from AE and decreased incidence of AE
Newer treatments for COPD

1. New LABA
   - Onbrez, Indacaterol
2. New LAMAs
   - Elkira, Aclidinium bromide
   - Seebri, Glycopyrronium
3. Daxas, roflumilast, PDE4 inhibitor
4. Mucolytics
   - Carbocisteine, Mucodyne
   - Erdotin, erdocistine
Onbrez, Indacaterol

- Once daily LABA
- £29
- Evidence of
  - Non-inferiority to tiotropium (different class of drug but similar use)
  - Superiority to BD salmeterol
  - Superiority to BD formoterol

Thorax 2010;65:473e479
AJRCCM 2010; 182:155–162
ERJ 2011; 37: 273–279
New LAMAs

- Spiriva (tiotropium) was the only LAMA, now there are options
- They may be more effective
- They may be safer
- They are cheaper
1. Eklira (Aclidinium)

• Twice daily LAMA 400mcg
• £28

• Good things:
  – Good device
  – Best improvement in SGRQ (vs. Placebo)
  – Few side-effects and possibly no CV s/e

• Bad things:
  – No adequate trials vs. competitors
2. Seebri (Glycopyrronium)

- Once daily LAMA
- £28 (compared with spiriva £33)
- Evidence of non-inferiority to tiotropium

Eur Respir J 2012; 40: 1106–1114
<table>
<thead>
<tr>
<th>Policy Statement</th>
<th>Long acting muscarinic antagonists (LAMAs) in COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy No:</td>
<td>PCN 61-2013 (replaces 53-2013)</td>
</tr>
<tr>
<td>Date of Issue</td>
<td>29th May 2013</td>
</tr>
<tr>
<td>Review Date:</td>
<td>May 2016 (Unless new published evidence becomes available before this date OR there is new published national guidance e.g. NICE)</td>
</tr>
</tbody>
</table>

**Recommendations:**
- Glycopyrronium (Seebri Breezhaler®) to be the first line LAMA of choice on the basis of evidence and cost effectiveness.
- Aclidinium (Eklira Genuair®) can be considered as an alternative device for patients who are unable to use the Seebri Breezhaler® / Spiriva Handihaler® devices
- Tiotropium Respimat® should no longer be recommended due to increasing reports of cardiovascular side effects and will be given a BLACK status on the prescribing advisory database.
COPD treatments in development

• Combination inhalers
  – **Once daily LABA/LAMA**
    - QVA, indacaterol /Glycopyrronium  *Novartis*
    - Anoro, Vilanterol/Umeclidinium  *GSK*
    - Olodaterol /tiotropium  *BI*
  – **Once daily LABA/ICS**
    - Relvar, Vilanterol/Fluticasone Fumarate Q3/2013  *GSK*
    - Zenthale, Formoterol/mometasone  *MSD*
  – **BD LABA/LAMA**
    - Formoterol fumarate /Aclidinium bromide  *Almirall*
    - Formoterol/glycopyrrolate  *Pearl*
  – **LABA**
    - olodaterol  *BI*
    - vilanterol  *GSK*
  – **LAMA** umeclidinium  *GSK*
  – **MABA** (both muscarinic antagonist and beta2 agonist)  *GSK*

• **Novel inhaled therapies**
  – Bimosiamose, pan-selectin antagonist  *Revotar*

• **Novel therapies**
  – RPL554, a PDE3 and PDE4 inhibitor tablet

Benefits of combined LABA/LAMA

Mean trough FEV1 at week 26
Asthma Case 1

- 25-year-old woman
- Asthma with night-time waking and some limitations to exercise
- Currently on Seretide 125 2 puffs BD

Options:

a) Seretide 250, 2 puffs BD
b) Seretide 125, 2 puffs TDS
c) No change
d) Montelukast
Asthma Case 2

• 25-year-old woman
• Asthma
• No symptoms
• Currently on Seretide 250 2 puffs BD

Options:

a) Seretide 125, 2 puffs BD
b) Flixot tide 125, 2 puffs BD
c) No change
COPD Case 1

- 65-year-old woman
- COPD, ex-smoker
- 1 exacerbation in past year
- $\text{FEV}_1$ 60% predicted
- Complaining of excessive breathlessness
- Currently on ‘blue and brown’

Options:
- a) Change to LAMA or LAMA and LABA
- b) Seretide 125 2 puffs BD
- c) No change

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>More Symptoms</th>
<th>Long-acting anticholinergic or Long-acting $\beta_2$-agonist</th>
</tr>
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<tbody>
<tr>
<td>Low</td>
<td></td>
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</table>

COPD Case 2

- 65-year-old woman
- COPD, ex-smoker
- No exacerbations in past year
- SOB on walking up hills
- FEV$_1$ 65% predicted
- Currently on Seretide 250 2puffs BD

Options:

a) Change to LABA and LAMA instead of seretide
b) Serevent 125 2 puffs BD
c) Add LAMA
d) No change

Unnecessary ICS
Summary

1. Increasing options for inhaled therapies for asthma and COPD
2. Reflected in increasing complexity of guidelines
3. Developments (once daily LAMA/LABA for COPD and once daily LABA/ICS for asthma) likely to offer greater advantage
4. Allows more appropriate and effective treatment
Or...

**ASTHMA**
- The right amount of ICS
- Maybe no LABA
- Never LABA alone
- Rarely LT OCS

**COPD**
- Maximal LABA/LAMA
- Maybe no ICS
- Never ICS alone
- Hopefully never on LT OCS
Many thanks for listening

• Any questions?

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Resources

• Inhaler guides (videos)
  http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

• Peak Flow Diary
  http://www.patient.co.uk/pdf/4684.pdf
Surrey Community Pharmacy

April 2013 – Medicines Management Matters, NW Surrey CCG

Glycopyrronium (Seebri Breezhaler®) is recommended as the first line LAMA of choice with aclidinium (Eklira genuair®) as an alternative device for patients unable to use the Seebri Breezhaler® device.
  • Spiriva (tiotropium) Respimat® is no longer recommended due to reports of cardiovascular side effects and has a BLACK status on the PAD. ERJ March 21, 2013
  • Practices may wish to consider switching patients from Spiriva (tiotropium) Handihaler® to Seebri Breezhaler®. Patients who have problems using the Handihaler® device may also have problems with the Breezhaler® as both require insertion of capsules for dosing in which case Eklira® would be a suitable alternative.

Jan 2013 – PCN minutes

Flutiform® inhaler for Asthma
The network were informed that Flutiform® is a recently launched combination inhaler and although recently launched it contains two established ingredients (Fluticasone & Formoterol). NICE guidance recommends that the least costly device that is suitable for an individual patient should be used if a combination inhaler is required. The network members concurred that Flutiform® is a cost effective alternative combination ICS/LABA. The network noted the price differential between the various combination ICS/LABA inhalers.

GP colleagues noted that if a spacer device is indicated for a patient, then the Aerocenter Plus® should be used as per the license (ie regular treatment of asthma where the use of a combination inhaled ICS/ LABA is appropriate – currently not SMART)
The network members discussed possible solutions to support implementation and requested that the author of the review discuss this with the manufacturers of Flutiform®.

Recommendations:
The Network supported the use of Flutiform® (in line with the license) as a first line alternative to Seretide Evohaler® and Symbicort Turbohaler® in adults and children over 12 years where LABA/ICS is indicated as per BTS and NHS Surrey Asthma Guidelines. (NB 250mcg strength licensed only from 18 years).
Individual practices may consider actively switching patients on Seretide Evohaler® to an appropriate dose of Flutiform® MDI or to review patients when it is clinically appropriate to step up or step down the dose of ICS/LABA.
Asthma quality standards - 2013

1. Diagnosed in accordance with BTS/SIGN guidance.
2. Assessed for occupational causes.
3. Written personalised action plan.
4. Training and assessment in inhaler technique
5. Structured review at least annually.
6. If respiratory symptoms - assessment of their asthma control.
7. If exacerbation - receive an objective measurement of severity at the time of presentation.
8. If severe or life-threatening acute exacerbation of asthma receive steroids within 1 hour.
9. If admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.
10. If received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.
11. People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.