

# Guidelines for Managing Stable COPD in Primary Care

NHS Calderdale CCG, NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Wakefield CCG

This guideline considers pharmacological and non-pharmacological treatments. A difference from previous guidelines is the use of the GOLD approach to guide management.

<http://goldcopd.org/global-strategy-diagnosis-management-prevention-copd-2016/>

## Principles that apply to all patients:

- Diagnosis should be confirmed by quality assured spirometry
- Pharmacological treatments are not always the most effective
- Patients who maintain physical activity will have better outcomes. This can be encouraged through early referral to Pulmonary Rehabilitation Programmes (see Pulmonary Rehabilitation Guidance)
- Prior to changes in medication, check inhaler technique and concordance  
<https://www.blf.org.uk/support-for-you/copd/health-care-professionals>
- Any changes to medications should be reviewed after 4 weeks to assess impact on health status, with discontinuation or substitution of treatments given for breathlessness if no improvement
- To assess the impact of COPD on the patient's wellbeing and daily life, consider the use of the COPD Assessment Test (CAT). Copies to download are available online at <http://www.catestonline.org> The CAT score is included in the CCG COPD review template.
- Co-morbidities play an important part in mortality of COPD. Patients should be assessed for Coronary Artery Disease, Anxiety & Depression, and Osteoporosis.
- If there is a past history or family history of asthma consider Asthma/COPD Overlap Syndrome (ACOS)- See Guidelines for Diagnosing COPD in Primary Care
- Inhaled steroids can increase the risk of pneumonia and indications for use have changed. They should only be prescribed when clearly indicated as per inhaler guidelines

## All patients at all stages of COPD should be:

- Offered pneumococcal and influenza vaccinations
- Offered smoking cessation where appropriate
- Encouraged to have regular exercise/activity - 30minutes of light exercise 5 times per week
- Encouraged to enroll on a Pulmonary Rehabilitation Programme (MRC 2-4) or referred for Physiotherapist assessment (MRC 5)
- Offered a short acting beta agonist for "as required" use
- Categorized and managed according to the GOLD grid (See Treatment Algorithm)

## Use the GOLD grid to allocate a category A-D for each patient

Assess breathlessness and symptoms

- Choose the left column (A or C) if CAT score <10 or MRC score is 0-1
- Choose the right column (D or B) if CAT score ≥10 or MRC is ≥2

Assess air flow limitation and exacerbation risk

- Choose the upper row (C or D) if:
  - FEV<sub>1</sub> is <50% predicted OR
  - the patient has 2 or more exacerbations in the last 12 months **OR**
  - the patient has been admitted with an exacerbation
- Choose the lower row (A or B) if:
  - FEV<sub>1</sub> is ≥50% predicted AND
  - the patient has had 0 or 1 exacerbation in the last 12 months **AND**
  - there were no admissions to hospital with an exacerbation

GOLD Categories	
C	D
A	B

Please use your local COPD Preferred Inhaler Guidelines to guide pharmacological therapy

Link

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NHS Calderdale, NHS Greater Huddersfield, NHS North Kirklees and NHS Wakefield CCG. Cross cluster respiratory group in collaboration with The Mid Yorkshire Hospitals NHS Trust and Calderdale and Huddersfield Foundation Trust.  
 Review due: September 2019 (unless clinical evidence base changes)

### Long Term Oxygen Therapy (LTOT)

Oxygen saturation should be checked 6 monthly in people with FEV1 <30% or <1.5 litres  
 Refer for home oxygen therapy assessment people with resting saturations ≤92% as per the Identification and Referral of COPD Patients for Home Oxygen Assessment guideline

### Theophyllines

Not routinely used in COPD. If considering this treatment referral to specialist services is recommended. Changes in breathlessness and health status will require review after 4 weeks. Check theophylline level at 4 to 6 weeks

### Mucolytics

These should not be routinely used in people with stable COPD. May be of use in people with chronic productive cough, review after 4 weeks and discontinue if no benefit

### Osteoporosis prophylaxis

Should be considered in people requiring frequent courses of oral corticosteroids (>2 courses per year) and in people on high doses of ICS (2mg/day beclometasone or equivalent) with a second risk factor. The risks of developing osteoporosis should be discussed with the patient

### Treatments considered unsuitable for COPD

Includes maintenance oral corticosteroids, prophylactic antibiotics, Alpha-1 antitrypsin replacement therapy, antioxidant therapies and antitussive therapy

### Review in Primary Care

It is strongly recommended that the CCG COPD template, linked to the Care Planning Template, is used during COPD patient reviews. Local templates may be used but should contain all of the components below:

Primary Care Review	All patients	FEV1 <30% predicted or GOLD 4
Frequency	AT LEAST ANNUAL	AT LEAST TWICE PER YEAR
Measurements to make	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> and FVC measurement</li> <li>• Record BMI</li> <li>• MRC Dyspnoea Score</li> <li>• COPD Assessment Test (CAT Score)</li> <li>• Consider measurement of saturation (SPO<sub>2</sub>) by oximetry in patients with severe airflow obstruction (FEV<sub>1</sub> 30-49% predicted)</li> </ul>	
		<ul style="list-style-type: none"> <li>• Full Blood Count</li> <li>• Measure saturation by oximetry (SPO<sub>2</sub>)</li> </ul>
Clinical Assessment	<ul style="list-style-type: none"> <li>• Smoking status and desire to quit</li> <li>• Adequacy of symptom control</li> <li>• Breathlessness and Exercise tolerance</li> <li>• Estimated exacerbation frequency</li> <li>• Need for pulmonary rehabilitation</li> <li>• Self-management advice</li> <li>• Need for referral to specialist and therapy services</li> <li>• Presence of complications</li> <li>• Inhaler technique</li> <li>• Consider referral to Expert Patient Programme</li> </ul>	
		<ul style="list-style-type: none"> <li>• Presence of cor pulmonale</li> <li>• Patients nutritional state</li> <li>• Presence of depression</li> <li>• Need for social services and occupational therapy</li> <li>• Consider palliative care requirements</li> </ul>

### MRC Dyspnoea Score

- 1) Not troubled with breathlessness except with strenuous exercise
- 2) Troubled by breathlessness when hurrying on the level or walking up a slight hill
- 3) Walks slower than people of the same age on the level because of breathlessness or has to stop for breath when walking at own pace on the level
- 4) Stops for breath after walking about 100 yards after a few minutes on the level
- 5) Too breathless to leave the house or breathless when dressing or undressing

## Management Of COPD

<b>Risk</b> Airflow limitation	<b>CATEGORY C</b> Few Symptoms and high risk of exacerbations	<b>CATEGORY D</b> Many symptoms & high risk of exacerbations	<b>Risk</b> Exacerbation history  2 or more  <b>Or</b>  ≥1 (Leading to hospital admission)	
	Gold 4	Stop Smoking		Stop Smoking
		Flu and Pneumonia vaccination		Flu and Pneumonia vaccination
		Increase or maintain activity		Pulmonary Rehabilitation
	Gold 3	Consider specialist referral		Consider specialist referral
		LAMA/ Long-acting B2-agonists as a combination inhaler		Consider Inhaled Cortico Steroid/ Long-acting B2-agonists + Long acting anticholinergic
<b>Refer to Inhaler Guidance</b>				
<b>Risk</b> Airflow limitation	<b>CATEGORY A</b> Few symptoms & low risk of exacerbations	<b>CATEGORY B</b> More significant symptoms & low risk of exacerbations	<b>Risk</b> Exacerbation history  1 (not leading to hospital admission)  <b>Or</b>  0	
	Gold 2	Stop Smoking		Stop Smoking
		Flu and Pneumonia vaccination		Flu and Pneumonia vaccination
		Increase or maintain activity		Pulmonary Rehabilitation
	Gold 1	Short-acting B2-agonists or Long acting anticholinergic and Short-acting B2-agonists		Long acting anticholinergic /Long-acting B2-agonists as a combination inhaler
<b>Low level of symptoms (CAT &lt;10 &amp; MRC 0-1)</b>		<b>Higher level of symptoms (CAT ≥10, MRC ≥2)</b>		

**References:**

- Global Strategy for Diagnosis, Management, and Prevention of COPD – 2016 <http://goldcopd.org/global-strategy-diagnosis-management-prevention-copd-2016/>
- NICE COPD Quality Standards <https://www.nice.org.uk/guidance/qs10> Updated Feb 2016
- Chronic obstructive pulmonary disease Management of chronic obstructive pulmonary disease in adults in primary and secondary care <https://www.nice.org.uk/guidance/cg101>
- An outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England <https://www.gov.uk/government/publications/an-outcomes-strategy-for-people-with-chronic-obstructive-pulmonary-disease-copd-and-asthma-in-england>

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