Helping you provide structured care for patients with COPD

On the following pages we've provided a snapshot of the content available in the PCRS-UK COPD Quick Guide. It's designed to help you provide structured care for people with COPD – based on the recent updated guidance by the National Institute for Health and Clinical Excellence*.

The authors of the COPD Guide to the Diagnosis and Management of COPD have pulled together the key aspects of the guidance relevant to primary care and distilled the information into this concise booklet. You can feel confident this 36 page resource, endorsed by the British Lung Foundation (BLF), offers straightforward practical advice. Better still, it has been written by healthcare professionals, working in the field of primary respiratory care. So it can easily be adopted by practices and used to help set standards locally for managing COPD in your practice. In this sample, we provide you with copies of pages 6 & 7 and 12 & 13 of the booklet.

Chapter headings and authors

You can also choose from a wide range of other expert primary care resources. Each one created by the PCRS-UK to help healthcare professionals deliver high-quality COPD services. These include: our ever-popular Opinion Sheets, summary guidance information, nursing tools such as protocols, clinic checklists and PGDs. Plus, you'll discover a range of resources aimed at professional development such as slide kits and online case studies to assist with personal reflection.

*Chronic obstructive pulmonary disease: management of chronic obstructive pulmonary disease in adults in primary and secondary care. NICE clinical guideline 101. London: National Clinical Guideline Centre.

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Diagnosis and management of COPD in primary care

A guide for those working in primary care

Primary Care Respiratory Society UK

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Content

Assessment of COPD in primary care

Dr Kevin Gruffydd-Jones

Assessment of COPD severity should be carried out regularly (at least annually, and more frequently for severe disease) to monitor disease progression, help determine prognosis and inform management strategies.

Traditionally, assessment of severity of COPD has been based on the degree of airflow limitation, but this correlates poorly with the impact of the disease upon the patient.

Table 3. NICE guidelines 2010[1] grading of severity of airflow obstruction.

Severity	Post-bronchodilator FEV_1 % predicted
Mild – Stage 1	≥ 80%*
Moderate – Stage 2	50-79%
Severe – Stage 3	30-49%
Very Severe – Stage 4	<30%**

*only in the presence of symptoms ** or ≤50% with respiratory failure

Patients should be assessed using a multidimensional assessment, which includes the degree of airflow limitation (Table 3) but also includes the following:

- Severity of cough (including purulence and viscosity of sputum)
- Degree of breathlessness using the MRC Dyspnoea Score[4] (reflects exercise tolerance and functional limitation) – (see Table 4)
- Smoking status
- Body Mass Index (BMI) weight (kg)/height (m^2). If the BMI is < 20, this reflects a poor prognosis
- Frequency of exacerbations in the previous year (mild exacerbation = needing an increase in treatment, severe exacerbation = needing oral steroids/hospitalisation)
- Oxygen saturation should be measured using pulse oximetry (especially where FEV_1 < 50% predicted). Oxygen saturations of ≤92% (measured when the patient is at rest, in a stable state and breathing air) may be suggestive of a "failing lung" and necessitate referral for further assessment
- Health status. The health impact of the disease upon the life of the patient can be measured by short self-completed health status questionnaires. The COPD Assessment Tool (CAT),[5] and Clinical COPD Questionnaire (CCQ),[6] are easy to use in primary care
- Assessment of co-morbidities
- In patients with exacerbations/failing lung:
  - Screen for depression/anxiety e.g.
    - During the last month have you often been bothered by feeling down, depressed or hopeless?
    - During the last month have you been bothered by having little interest or pleasure in doing things?
    - Do you feel upset or frightened by your attacks of breathlessness?

  A positive answer should prompt more formal assessment of the depression
  - Consider screening for osteoporosis
  - Summarise other co-morbidities (e.g. heart problems, osteoarthritis)
- Multidimensional assessment tools have been developed to assess disease severity and reflect prognosis. These include measurement of:
  - **B**ody Mass Index, **O**bstruction (Fev-1% predicted), **D**yspnoea (MRC score), **E**xercise (as measured by 6- minute walking test) BODE index[7]
  - Of more practical use in primary care is the DOSE[8] score:
    - Dyspnoea (MRC Score)
    - Obstruction (FEV_1 % predicted)
    - Smoking status
    - Exacerbation frequency
- Social needs. Record social support and needs (including carers and allowances)

Table 4. Medical Research Council (MRC) Dyspnoea Score.[4]

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100m or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing

Figure 2: Algorithm for Patient-Centred Management of Stable COPD in Primary Care.

ALL PATIENTS

- Smoking cessation advice
- Patient education / self management
- Assess co-morbidity
- BMI: Dietary advice if >25, specialist dietary referral if <20
- Exercise promotion
- Pneumococcal vaccination
- Annual influenza vaccination

SYMPTOMS?

Breathlessness
Short-acting bronchodilators (β-agonist/anticholinergic) for relief of symptoms

Persistent symptoms
See pharmacotherapy algorithm (page 13)

Productive cough
Consider mucolytics

FUNCTIONAL LIMITATION?

MRC score ≥3

Optimise pharmacotherapy
See pharmacotherapy algorithm (page 13)

Offer pulmonary rehabilitation

Screen for anxiety/depression

EXACERBATIONS

(Oral steroids/ antibiotics/ hospital admissions)

Optimise pharmacotherapy

Discuss action plans including use of standby oral steroids and antibiotics

HYPOXIA?

Oxygen saturation ≤92% at rest in air

FEV_1 <30% predicted

Refer for oxygen assessment

HOLISTIC CARE

Check social support (e.g. carers and benefits)

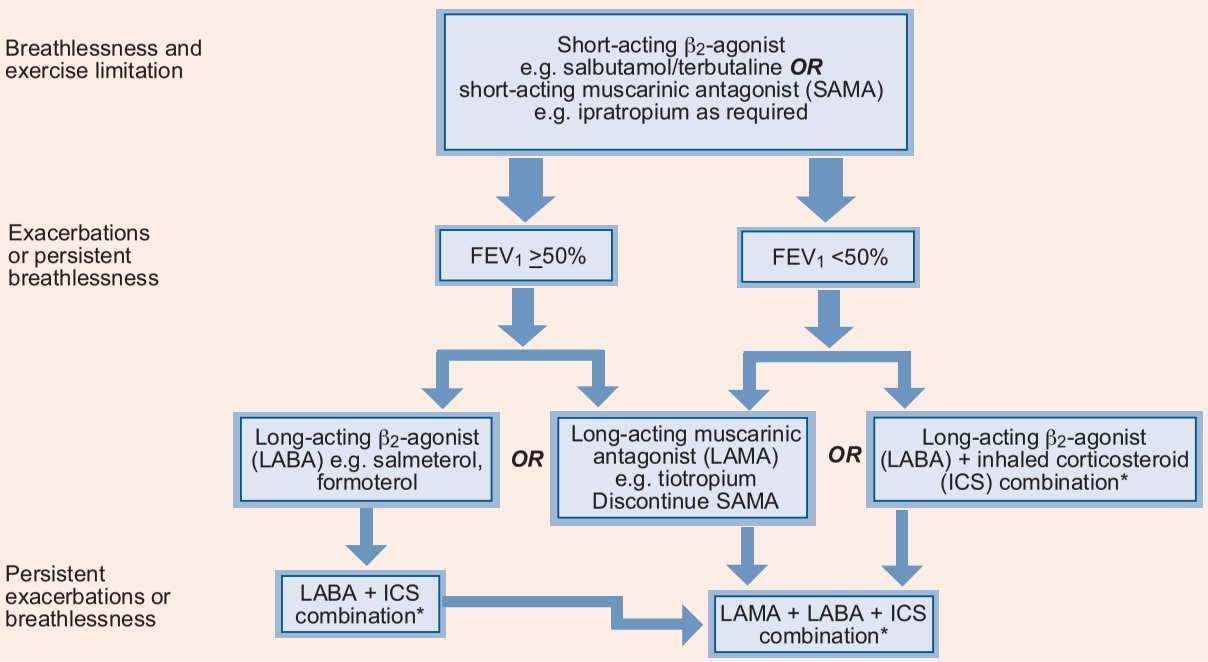
Treat co-morbidities

Consider palliative therapy or secondary care referral for resistant symptoms

Refer to specialist palliative care teams for end-of-life care

Figure 3: Inhaled pharmacotherapy algorithm.[1]
Adapted from NICE 2010 Guidelines

Choose a drug based on the person's response and preference (including choice of device, side-effects and cost)



**Consider LAMA + LABA if ICS declined or not tolerated*

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This 'Guide to diagnosis and management of COPD' is just a small part of what the PCRS-UK can do for you, your colleagues and your practice team. Join the PCRS-UK today and you can join the people already making a difference in respiratory primary care.

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