Triple therapy in COPD

PCRS advocate a pragmatic approach to the pharmacological management of patients with COPD guided by the predominance of breathlessness and/or exacerbations and the presence or absence of comorbid asthma. Clinicians must undertake a holistic evaluation for alternative causes of persistent daily symptoms or repeated exacerbations and consider seeking advice from a respiratory specialist before escalating to triple therapy (a respiratory specialist may be a GP/nurse/consultant).

Background

Triple therapy for patients with chronic obstructive pulmonary disease (COPD) refers to the combination of long-acting muscarinic antagonists (LAMA), long-acting beta2 agonists (LABA) and inhaled corticosteroids (ICS). Given the small but increased risk of pneumonia for patients prescribed ICS as part of a triple therapy regimen, it is essential to that such treatment is only prescribed for patients likely to derive a clinical benefit.

Current guidance from NICE issued in 2019 advises that for patients with COPD and persistent symptoms on dual therapy (LAMA+LABA or LABA+ICS) a clinical review is conducted prior to initiating triple therapy to ensure pharmacological and non-pharmacological management is optimised and tobacco dependence has been addressed.[1] The review should also evaluate whether the acute episodes of worsening symptoms and any impact of day-to-day symptoms on quality of life are due to COPD and not caused by another physical or mental health condition or due to environmental/social factors such as poor living conditions.

Triple therapy can be considered for patients whose day-to-day symptoms are adversely impacting their quality of life OR have had a severe exacerbation requiring hospitalisation OR have had 2 moderate exacerbations within the previous 12 months. For patients taking LABA+LAMA whose day-to-day symptoms are adversely impacting their quality of life, a 3-month trial of triple therapy may be considered; if no improvement in symptoms (clinician assessment) or reduction in exacerbation frequency is achieved then patients should be switched back to LABA+LAMA. GOLD guidelines advocate that treatment should be guided by predominant breathlessness or exacerbations and that ICS therapy should be considered only as part of a triple therapy regimen and for patients with persistent symptoms and co-existing features of asthma or a raised eosinophil count (>300 cells/mL) while not receiving steroid treatment.[2]

PCRS position

- PCRS advocate a pragmatic approach to the pharmacological management of patients with COPD guided by the predominance of breathlessness and/or exacerbations and the presence or absence of comorbid asthma.[3,4]
  - Triple therapy should usually be reserved for patients with persistent daily symptoms or repeated exacerbations despite optimal dual therapy after a careful review of potential alternative causes.
  - Triple therapy is not generally beneficial for patients with COPD with predominant breathlessness without asthma, with no severe exacerbations, or fewer than 2 exacerbations in the last year.
  - Consider a single inhaler triple therapy device to improve adherence, reduce inhaler technique errors and reduce inhaler burden.
- Clinicians must undertake a holistic evaluation for alternative causes of persistent daily symptoms or repeated exacerbations which should include:
  - Review of diagnosis
  - Optimisation of pharmacological therapy (inhaler technique, adherence)
  - Optimisation of nonpharmacological therapy including pulmonary rehabilitation and vaccinations
  - Smoking cessation/tobacco dependence assessment
  - Co-morbidities
  - Any potential environmental/social factors (e.g. poor living conditions)
- If after holistic evaluation and treatment optimisation, daily symptoms or repeated exacerbations persist, clinicians should consider seeking advice from a respiratory specialist before escalating to triple therapy (a respiratory specialist may be a GP/nurse/consultant).

References
1. https://www.nice.org.uk/guidance/ng115. Accessed August 2023.
2. https://goldcopd.org/2023-gold-report-2/. Accessed August 2023.
3. https://www.pcrs-uk.org/resource/pcrs-consensus-guide-managing-copd. Accessed August 2023.
4. https://www.pcrs-uk.org/resource/gold-2023-implications-primary-care-patients-copd-uk. Accessed August 2023.