COPD prevention and treatment: The role of triple therapy tobacco dependence, pulmonary rehabilitation and vaccinations

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Chronic obstructive pulmonary disease (COPD) is a preventable and treatable condition that remains a major cause of morbidity and mortality worldwide. The impact on patients, families and healthcare systems is huge, yet many exacerbations, hospitalisations and disease progression can be prevented if the fundamentals of care are delivered consistently, including early and accurate diagnosis.

Inhaled triple therapy (inhaled corticosteroids/long-acting β2 agonists/long-acting muscarinic antagonists; ICS/LABA/LAMA) has a clear place in the management of some patients, particularly those with eosinophilia and frequent or severe exacerbations. But inhaler escalation is not the only answer, and inhaler technique, adherence and device choice reviews are equally important.

The most important triple therapy, one that every COPD patient can and should benefit from, is treating tobacco dependence, referral to pulmonary rehabilitation (PR) (where appropriate) and ensuring vaccinations are up to date. Alongside this, NICE[1] and GOLD[2] also highlight the importance of self-management and comorbidity care. These interventions reduce exacerbations, improve quality of life and ultimately save lives.

Triple Therapy: Getting the Balance Right

Treating Tobacco Dependence: the Cornerstone of COPD Care

Stopping tobacco use is the single most effective intervention for slowing disease progression in COPD. It improves symptoms, reduces exacerbations and extends life expectancy. Yet many patients are only asked about smoking status and not offered evidence-based Very Brief Advice (VBA) and signposted to more intensive support.

PCRS: How to become a Quit Catalyst

ASK – Do you smoke?

ADVICE – Did you know the best way to stop is with a combination of support and treatment which is available on the NHS?

ACT – Signpost to support available if interested

https://www.pcrs-uk.org/resource/current/become-quit-catalyst

Every consultation should include a clear supportive conversation about stopping tobacco, with access to evidence-based treatment. This means behavioural support combined with licensed pharmacotherapy such as combination nicotine replacement therapy, varenicline, cytisinicline (cytisine, belnifrem) or

bupropion, depending on patient preference and suitability. 'Swap to Stop' schemes using vapes as a harm reduction tool should also be considered. Too often, 'willpower' alone is relied on, yet evidence shows quit rates are far higher with structured support and treatment.

We should also recognise that tobacco dependence is a long-term relapsing condition, not just a 'bad habit'. Offering help at every stage, celebrating small steps and never closing the door to future quit attempts are all essential.

Pulmonary Rehabilitation (PR): Improving Quality of Life and Outcomes

PR remains one of the most cost-effective interventions in COPD. It improves exercise tolerance, reduces breathlessness, enhances quality of life and lowers hospital admissions. Despite this, referral rates remain far too low.

Patients often see PR as 'just exercise', but it is much more. Education, peer support and self-management skills are built into every programme, helping patients gain confidence in living with COPD. Referring early,not just after hospital admission, is key. Every clinician should think: "Has my patient been offered PR?"

The way PR is promoted is important

ASK – How has breathlessness impacted on your life?

ADVICE – PR helps you breathe easier, feel better, build confidence, reduce breathlessness and fatigue, lower your risk of flare-ups, and even get back to doing more (including work if relevant) – I strongly recommend it

ACT – Signpost accordingly

- https://www.ipcrg.org/clinicaltopics/PR
- https://www.pcrs-uk.org/resource/current/communicating-benefits-pulmonary-rehabilitation
- https://www.pcrs-uk.org/resource/current/breathing-thinking-functioning-model-support-management-breathlessness

Barriers remain, including access, waiting times and patient motivation/knowledge. Digital and home-based programmes can help increase reach, but awareness among clinicians is still a big hurdle.

Note: If a person isn't eligible for PR or waiting times are long, increasing safe levels of activity/movement should be encouraged. The scale of breathlessness infographic may help during consultations https://www.ipcrg.org/resources/search-resources/scale-of-breathlessness-infographic

Vaccinations: Reducing Exacerbations and Protecting Lung Health

Respiratory infections are a leading trigger for COPD exacerbations. Vaccinations against influenza, pneumococcal disease, COVID-19 and respiratory syncytial virus are vital in protecting this vulnerable group.

Uptake remains variable, but every review provides an opportunity to check vaccination status. Discussing vaccines as part of routine COPD care helps normalise their role as disease-modifying interventions, not just seasonal extras.

Promoting vaccination uptake example

ASK – Great news, you qualify for a flu vaccination

ADVICE – Vaccines can help protect lung health and reduce lung attacks

ACT – Signpost or offer vaccine

Top Tip: If a smoker: did you know you're 5× less likely to get flu and 2× less likely to get pneumonia if you're a non-smoker

Self-Management: Empowering Patients

Supporting patients to take control of their condition is fundamental. Self-management includes correct inhaler technique, personalised action plans and guidance on when and how to use rescue packs if prescribed. Patients who understand their COPD and feel confident responding to worsening symptoms are less likely to present in crisis. These are simple but powerful interventions that reduce admissions and improve patient confidence in day-to-day life.

Comorbidities: Don't Miss the Bigger Picture

COPD rarely exists in isolation. Cardiovascular disease, osteoporosis, anxiety and depression are common and can worsen symptoms and outcomes. A quick screen during reviews – checking cardiovascular risk3, mental wellbeing and bone health – ensures we are treating the whole patient, not just their lungs.

See the PCRS Beyond the Lungs resource for further information on this: https://www.pcrs-uk.org/resource/current/beyond-lungs

Patient and Clinician Aids

Simple tools can help keep the fundamentals of COPD care front of mind during busy consultations.

- **PCRS/AstraZeneca Ltd COPD Risk Slider:** An excellent visual reminder for clinicians, ensuring the basics such as tobacco dependence support, vaccinations and PR are consistently covered.
  https://www.pcrs-uk.org/resource/current/copd-risk-slider
- **IPCRG Visual Wheel**: A patient-centred aid that highlights key discussion points in COPD reviews, making it easier for patients to understand and engage with their care.
  https://www.ipcrg.org/copdwheel
- **CardioPulmonary risk template** can be requested at: population-health@astrazeneca.com

These resources can support conversations, improve adherence to guidelines and ensure no patient misses out on the proven interventions that make the biggest difference.

Bringing It All Together in Primary Care Practice

The fundamentals of COPD care are simple but are too often overlooked. At every review, clinicians should ask about the five fundamentals and practise using the 'Ask, Advise and Act' model so it becomes part of routine care. By prioritising these steps, we can reduce exacerbations, slow disease progression and give patients the best possible quality of life.

Inhaled triple therapy has a role in some patients, but the true 'triple therapy' that all patients should receive is tobacco dependence treatment, pulmonary rehabilitation, and vaccinations.

Key Practice Points

- **Ask, Advise, Act at every review** – tobacco dependence support, vaccination status and PR should be considered as routine fundamentals, not optional extras.
- **Triple therapy is more than inhalers** – inhaled triple therapy has its place, but every COPD patient should be offered the 'true triple therapy': stop smoking support, PR (if eligible) and vaccinations. If the patient is not eligible for PR, increased activity should certainly be encouraged.
- **Keep the basics front of mind** – simple visual tools such as the PCRS COPD Risk Slider and the IPCRG Visual Wheel can help ensure the fundamentals are consistently delivered in everyday practice.

References
1. National Institute for Health and Care Excellence (NICE). Chronic obstructive pulmonary disease in over 16s: diagnosis and management. [NG115]. December 2018. Available at: https://www.nice.org.uk/guidance/ng115 [Accessed October 2025].
2. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for Prevention, Diagnosis and Management of COPD: 2025 Report. Available at: https://goldcopd.org/2025-gold-report/ [Accessed October 2025].
3. Chronic Obstructive Pulmonary Disease and the Management of Cardiovascular Risk in the UK: A Systematic Literature Review and Modified Delphi Study. Shrikrishna, D; Steer, J; Bostock, B; Dickinson, S et al. https://pmc.ncbi.nlm.nih.gov/articles/PMC12206411/ (Accessed October 2025).