PCRS Position Statement

Triple therapy in Chronic Obstructive Pulmonary Disease (COPD)

June 2026

Summary of PCRS position

The Primary Care Respiratory Society (PCRS) advocates a pragmatic approach to the pharmacological management of patients with chronic obstructive pulmonary disease (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specialist before escalating to triple therapy.[1] The inhaled corticosteroid element of triple therapy should be withdrawn if there is no benefit to symptoms or frequency of exacerbations after a 3–6-month trial or the patient develops severe or recurrent pneumonia or mycobacterial infection whilst on treatment.

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Background

Triple therapy for patients with COPD refers to the combination of long-acting muscarinic antagonists (LAMA), long-acting beta$_2$ agonists (LABA) and inhaled corticosteroids (ICS). Given the small but increased risk of pneumonia for patients prescribed ICS, it is essential that such treatment is only prescribed for patients likely to derive a clinical benefit.

Current guidance from the National Institute for Health and Care Excellence (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.[2] 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 one or more 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. Global Initiative for Chronic Obstructive Lung Disease (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.[3]

Key issues

Withdrawal of triple therapy

Patients who are already on triple therapy should be reviewed regularly to confirm ongoing benefit and minimise harm. Withdrawal of the ICS component may be appropriate where there is no improvement after an adequate trial (eg, 3–6 months) or where patients develop severe or recurrent pneumonia, or mycobacterial infection on treatment. Withdrawal may also be considered in those who experience worsening of co-morbidities such as diabetes, skin fragility or osteoporosis. Step-down to dual bronchodilation (LABA+LAMA) should be undertaken with close monitoring of symptoms and exacerbations, reinstating ICS only if deterioration occurs.

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 co-morbid asthma.[4,5]
    - 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 two exacerbations in the last year.
    - Consider a single inhaler triple therapy device to improve adherence, reduce inhaler technique errors and reduce inhaler burden. A spacer should be used if a pressurised metered-dose inhaler (pMDI) is chosen.

- Clinicians must undertake a holistic evaluation[6] 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 non-pharmacological therapy including pulmonary rehabilitation and vaccinations
    - Smoking cessation/tobacco dependence assessment
    - Co-morbidities
    - Any potential environmental/social factors (eg, 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.

- The ICS element of triple therapy should be withdrawn if there is no benefit to symptoms or frequency of exacerbations after a 3–6-month trial, or the patient develops severe or recurrent pneumonia[7] or mycobacterial infection whilst on treatment.

References

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