PCRS-UK Update

10th June 2018

PCRS-UK Campaigns

Campaign	Key Message / theme
Education	Better education = better care; be trained to do the job you do
Diagnosis	Accurate diagnosis is the basic building block of good care
Tobacco dependency	Long term health condition, key clinical responsibility for all health professionals; tackling it should be routine part of care
Supported Self Management	Making the most of available time (consultation) and resources and doing the right thing the right way
Getting research into practice	Implementation evidence/considerations need to be a key driver throughout R&D /guideline/policy development process

Pragmatic Advice – COPD
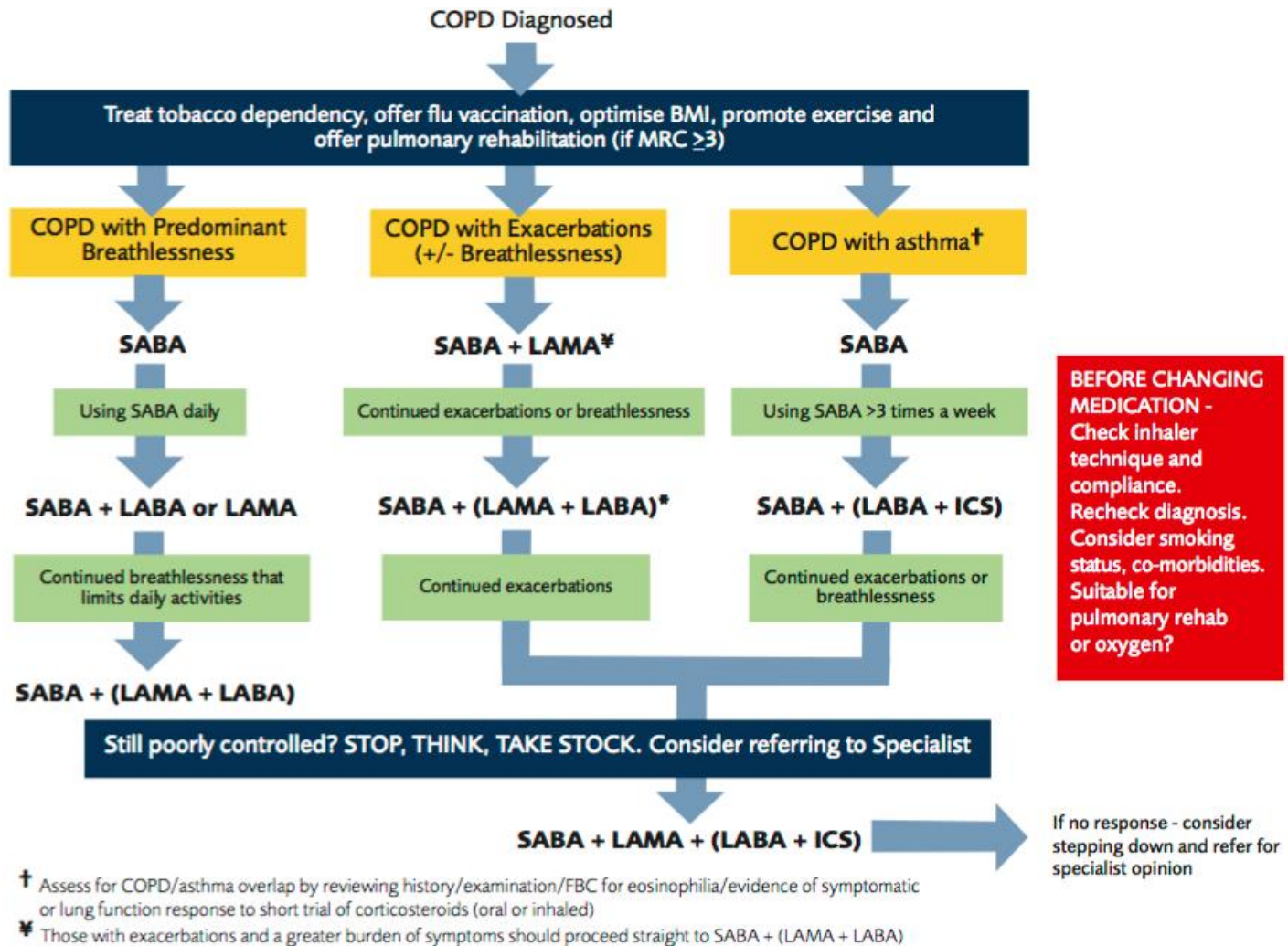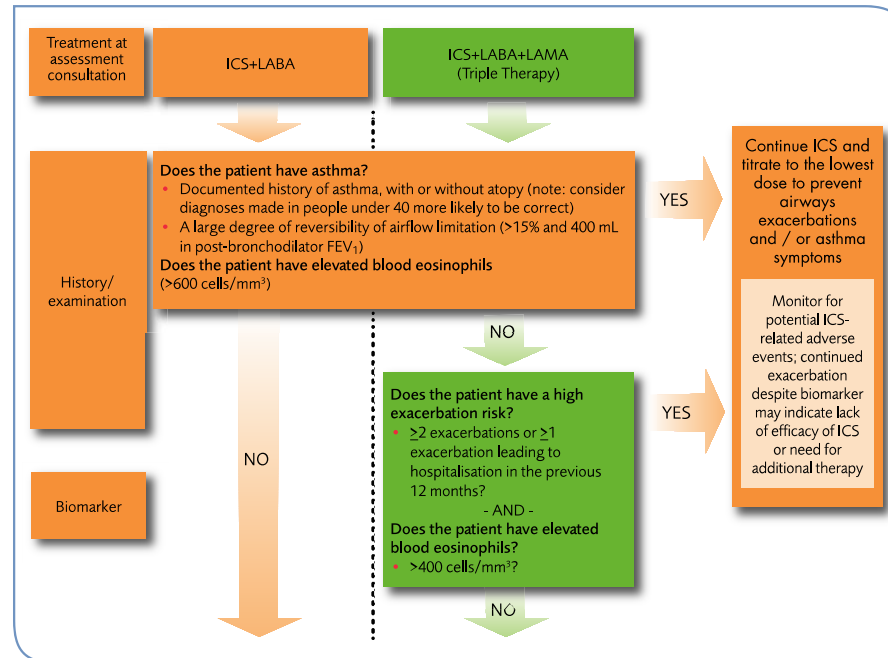
Pragmatic Advice – Step down

Evaluation of appropriateness of inhaled corticosteroid (ICS) therapy in COPD and guidance on ICS withdrawal

This guide provides an algorithm to identify people with chronic obstructive pulmonary disease (COPD) who might benefit from ICS treatment and those in whom it may not be appropriate, and an approach to withdrawing ICS in patients in whom it is not needed.

- In symptomatic patients with COPD at low risk of exacerbation, bronchodilation should be the first-line treatment. [GOLD 2017]. In symptomatic patients on monotherapy, treatment can be stepped up to a combination long-acting β2-agonist plus long acting muscarinic antagonist (LABA+ LAMA), and for patients with severe breathlessness (CAT score 10 or MRC grade 2) initial therapy with LABA+LAMA may be considered [GOLD 2017].

- In patients with symptoms (CAT score <10 or MRC grade <2) at high risk of an exacerbation,

Continued on next page

Treatment at assessment consultation

ICS+LABA

ICS+LABA+LAMA (Triple Therapy)

History/ examination

Does the patient have asthma?
- Documented history of asthma, with or without atopy (note: consider diagnoses made in people under 40 more likely to be correct)
- A large degree of reversibility of airflow limitation (>15% and 400 mL in post-bronchodilator FEV_1)

Does the patient have elevated blood eosinophils (>600 cells/mm³)

YES → **Continue ICS and titrate to the lowest dose to prevent airways exacerbations and / or asthma symptoms**

NO

Biomarker

Does the patient have a high exacerbation risk?
- ≥ 2 exacerbations or ≥ 1 exacerbation leading to hospitalisation in the previous 12 months?
  - AND -
Does the patient have elevated blood eosinophils?
- >400 cells/mm³?

YES → **Monitor for potential ICS-related adverse events; continued exacerbation despite biomarker may indicate lack of efficacy of ICS or need for additional therapy**

NO

NO

Pragmatic Advice – asthma

Asthma Guidelines in Practice – A PCRS-UK Consensus

Asthma Guidelines in Practice – A PCRS-UK Consensus was commissioned to provide clarity on aspects of diagnosis, management and monitoring of asthma that are uncertain due to differences between current national guidelines. The article has been written by Dr Luke Daines (GP and Academic Clinical Fellow, University of Edinburgh), in conjunction with GP colleagues, Duncan Keeley, Kevin Gruffydd Jones, Steve Holmes and nurse colleagues, Val Gerrard and Carol Stonham. It is based on the recently published PCRS-UK briefing paper (see https://pcrs-uk.org/sites/pcrs-uk.org/files/BriefingAsthmaGuidelines_V3.docx). This article focuses on mild/moderate asthma, for severe asthma please see British Thoracic Society/Scottish Intercollegiate Guideline Network. 2016. British Guideline on the Management of Asthma. Available from: http://www.sign.ac.uk/assets/sign153.pdf

Introduction

Asthma is a chronic respiratory condition affecting an estimated 5.4 million people in the UK.[1] Individuals with asthma suffer from wheeze, shortness of breath, cough and chest tightness, limiting everyday activities and fulfilment of roles at home and work.[2]

In the UK, public sector spending for asthma exceeds £1.1 billion each year, with the majority of costs (74%) arising from prescriptions and the estimated 6.4 million primary care consultations that occur each year.[3] Evidence-based management can maintain good day-to-day control for most people with asthma and substantially reduce the risk of asthma attacks.[2]

UK specific national guidelines for asthma management are now available from two sources: the National Institute for Health and Care Excellence (NICE) and British Thoracic Society / Scottish Intercollegiate Guideline Network (BTS/SIGN).[2,4] Whilst the BTS/SIGN guideline covers all aspects of asthma care, the NICE guideline concentrates on diagnosis, monitoring and chronic management. Although broadly similar in methodology, NICE include a thorough health economic evaluation, which other guidelines do not.[4] Subsequently differences in management recommendations can occur if there is little or no clinical difference between interventions.

Recommendations for the diagnosis of asthma also differ between NICE and BTS/SIGN guidelines.[2,4] Achieving a clear consensus for the best diagnostic strategy for asthma is a particular challenge as on top of economic and implementation considerations, the definition of asthma is also evolving.[4] Traditionally a diagnosis of asthma was based on symptoms and demonstration of variable obstructive airflow on lung function testing.[2,5] Yet, more recent definitions of asthma include airway inflammation and airway hyper-responsiveness to incorporate the subtypes of asthma identified through recent research on genetics and pathophysiological mechanisms.[2] This changing understanding of asthma has delivered new ways in which to test and treat for asthma subtypes and may in the future lead to asthma being 'deconstructed' into distinct 'treatable traits'.[5,6] Until then, a clear pragmatic way forward is needed to guide clinicians in non-specialist settings, where most asthma cases are diagnosed.[6]

Rationale for PCRS-UK consensus

In response to the uncertainty faced by many primary care clinicians in light of conflicting recommendations from national guidelines, this article developed by PCRS-UK members, aims to provide a clear, concise and pragmatic view on the diagnosis, management and monitoring of asthma in primary care. This article does not attempt to reproduce all the details contained in each guideline, but instead focuses on the areas that vary substantially between NICE and BTS/SIGN versions, offering a workable solution.

Recommendations

Asthma diagnosis

There is no definitive gold standard test which can categorically confirm or refute the diagnosis of asthma. Therefore, the diagnosis of asthma is made clinically following a structured clinical assessment; a careful integration of evidence from a wide variety of sources.[2,4] Key components of a structured clinical assessment include a detailed history, examination, review of the patient's clinical records and previously completed investigation results (e.g. peak expiratory flow, spirometry, blood eosinophils from a full blood count).

When taking a history, ask about wheeze, shortness of breath, cough and chest tightness, the most suggestive symptoms of asthma.[2,4] Symptoms usually occur in episodes with no (or minimal) symptoms between episodes.[2] Combinations of symptoms (particularly wheeze, cough and shortness of breath) occurring in episodes are more useful for identifying asthma than individual symptoms, particularly in children.[7] Ask about variability in symptoms through the day and between seasons. Clarify any triggers that provoke or worsen symptoms,[4] and in adults, check specifically for work-related factors. Remember to enquire about personal or family history of other atopic conditions such as allergic rhinitis or eczema.[4] Information from the patient clinical record, including previous respiratory illnesses, treatments and responses and previous examination findings (particularly wheeze heard on chest auscultation by a health professional) can further build the clinical picture.

Box 3. Factors that may confound the accuracy of FeNO in making an asthma diagnosis[2,12,13]

Increased levels in men, tall people, and those with a diet high in nitrates (e.g. spinach, broccoli).

Increased levels in individuals with allergic rhinitis exposed to an allergen (even without respiratory symptoms)

Increased levels in those with rhinovirus infection (inconsistent effect in those with asthma)

Lower levels observed in children (N.B. accordingly a lower reference range is used)

Reduced levels in cigarette smokers

Reduced levels by inhaled or oral steroids

Box 4. Common causes of poor asthma control

Incorrect diagnosis. Or co-morbidity that has been missed

Lack of medication adherence

Current treatment is unsuitable

Under-use of ICS. Or overuse of SABAs

Inappropriate inhaler technique

Failure to use a spacer with ICS delivered by a metered dose inhaler

Smoking (active or passive) – ideally use a carbon monoxide meter to monitor smoking
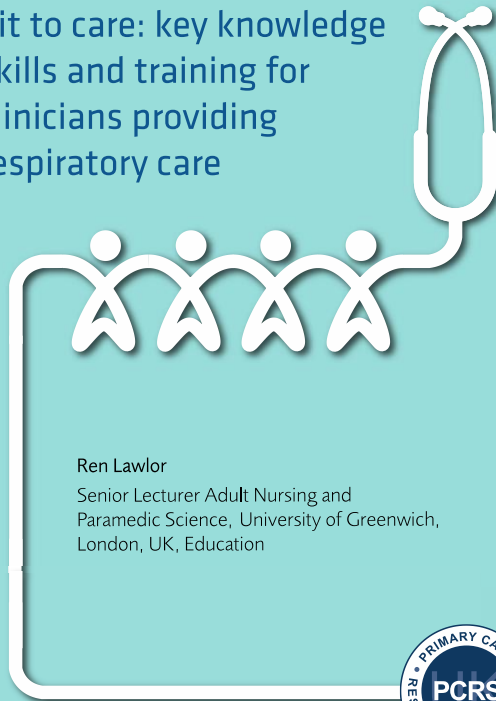
Exposure to occupational triggers

Seasonal or environmental factors

Psychosocial reasons, including ideas and concerns about asthma / treatment

Health professional Standards

Fit to care: key knowledge skills and training for clinicians providing respiratory care

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Key knowledge and skills required for clinicians providing STANDARD RESPIRATORY CARE

Skills	Knowledge	Training

• Accurately record clinical data and understand its significance, for example:
 	
  o Heart rate and rhythm, respiratory rate, pulse oximetry, peak flow rate, blood pressure, carbon monoxide level
 	
  o Scoring tools: RCP questions/ACT questionnaire, CAT score, MRC Breathlessness Scale
 	
  o Mental health scoring tools
 	
• Understanding of commonly used respiratory medications including indications, safety, optimal dosing, inhaler and NRT delivery devices and techniques
 	
• Understanding of non-pharmacological interventions such as weight management, physical activity and
	• Good understanding of respiratory anatomy and function
	
	• Good understanding of more common respiratory pathophysiology
	
	• Familiar with local, national and, where relevant, international guidelines for management of asthma and COPD, for example:
	
	https://www.brit-thoracic.org.uk/guidelines-and-quality-standards/asthma-guideline/
	
	https://www.nice.org.uk/guidance/cg101
		• Clinicians working at this level should have basic training in how to conduct a respiratory review accurately in a well-managed patient living with a respiratory disease
		
		• Local NHS approved training/in-house training with a suitably qualified professional with an expertise in the field of respiratory care
		
		• Ongoing clinical supervision with a qualified mentor working at an advanced or expert level in the field of respiratory care
		
		• Completion of NCSCT online training 'Very Brief Advice on Smoking' or similar online, locally provided accredited course, for example:
		
		http://elearning.ncsct.co.uk/vba-stage_1

Primary Care Respiratory Academy

Primary Care Respiratory Academy

Latest resources

NEW	Laying down the challenges	COMMISSIONING	▶ Video	WATCH VIDEO
NEW	How do we redesign our services?	COMMISSIONING	▶ Video	WATCH VIDEO
	Tailoring a plan for supported self-manageme…	CLINICAL	🌐 Article	READ ARTICLE
	Clinical review and risk stratification	COMMISSIONING	🌐 Article	READ ARTICLE
	The importance of choosing the right inhaler	CLINICAL	▶ Video	WATCH VIDEO
	Asthma guidance – part 2	CLINICAL	▶ Video	WATCH VIDEO

PCRS
PRIMARY CARE RESPIRATORY SOCIETY UK

Taskforce

Our new logo

Our new logo retains the use of 'PCRS' blue. It expresses respiratory care by featuring a lung graphic and combines it with an evolved existing people graphic for a human touch. It uses a semi-serif font, Avenir Serif Libre, in the name to make the brand stand out and convey contemporary authority. This logo also communicates a sense of the positive benefits of PCRS membership, connecting people as part of a dedicated community of practice.