PCRS-UK Update
10th June 2018
## PCRS-UK Campaigns

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

COPD Diagnosed

Treat tobacco dependency, offer flu vaccination, optimise BMI, promote exercise and offer pulmonary rehabilitation (if MRC ≥3)

COPD with Predominant Breathlessness

COPD with Exacerbations (+/- Breathlessness)

COPD with asthma†

SABA

SABA + LAMA‡

SABA + (LABA + ICS)

Before changing medication - Check inhaler technique and compliance. Recheck diagnosis. Consider smoking status, co-morbidities. Suitable for pulmonary rehab or oxygen?

Still poorly controlled? STOP, THINK, TAKE STOCK. Consider referring to Specialist

SABA + LAMA + (LABA + ICS)

If no response - consider stepping down and refer for specialist opinion

† Assess for COPD/asthma overlap by reviewing history/examination/FBC for eosinophilia/evidence of symptomatic or lung function response to short trial of corticosteroids (oral or inhaled)

‡ Those with exacerbations and a greater burden of symptoms should proceed straight to SABA + (LAMA + LABA)

Whilst the use of LAMA and LABA in combination is recommended as an option by both GOLD and NICE for patients with exacerbations of COPD, this is not a licensed indication
Pragmatic Advice – Step down

Primary Care Respiratory Society

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.

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

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

Continued on next page
Pragmatic Advice – asthma

Asthma Guidelines in Practice – A PCRS-UK Consensus

Introduction

Asthma is a chronic respiratory condition affecting an estimated 5.4 million people in the UK. Individuals with asthma suffer from wheeze, shortness of breath, cough and chest tightness, limiting everyday activities and fullfillment of roles at home and work. 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. Evidence-based management can maintain good day-to-day control for most people with asthma and substantially reduce the risk of asthma attacks.

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). 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 includes a thorough health economic evaluation, which other guidelines do not. Consequently 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. 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. Traditionally a diagnosis of asthma was based on symptoms and demonstration of variable obstructive airflow on lung function testing. 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. 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. Until then, a clear pragmatic way forward is needed to guide clinicians in non-specialist settings, where most asthma cases are diagnosed.

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 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. 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. Symptoms usually occur in episodes with no (or minimal) symptoms between episodes. 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. Ask about variability in symptoms throughout the day and between reasons. Carefully trigger provocation and worsening symptoms, 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. 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

- 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 in 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.
- Underuse 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.
Fit to care: key knowledge skills and training for clinicians providing respiratory care

Ren Lawlor
Senior Lecturer Adult Nursing and Paramedic Science, University of Greenwich, London, UK, Education

Key knowledge and skills required for clinicians providing STANDARD RESPIRATORY CARE

Skills
- Accurately record clinical data and understand its significance, for example:
  - Heart rate and rhythm, respiratory rate, pulse oximetry, peak flow rate, blood pressure, carbon monoxide level
  - Scoring tools: RCP questions/ACT questionnaire, CAT score, MRC Breathlessness Scale
- 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

Knowledge
- 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.nice.org.uk/guidance/cg101

Training
- 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

Future meetings

**Glasgow**
12th Jun 2018
Doubletree by Hilton Strathclyde,

**London East**
14th Jun 2018
DoubleTree Hilton Docklands Riverside,

**Leeds**
19th Jun 2018
Weetwood Hall, Leeds
## Latest resources

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Our mission is to **prevent more people from developing lung disease**, and to transform the care of people living with lung disease.

We’re bringing together the most influential voices in UK lung health to create a new vision for better services for everyone affected by lung disease.

[About the taskforce](#)
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.
PCRS-UK National Respiratory Conference

BUILDING CONFIDENCE IN A CHANGING WORLD

28-29th September 2018
Telford International Centre

The *must attend* conference for all professionals involved in respiratory care in a primary or community care setting

Register Now