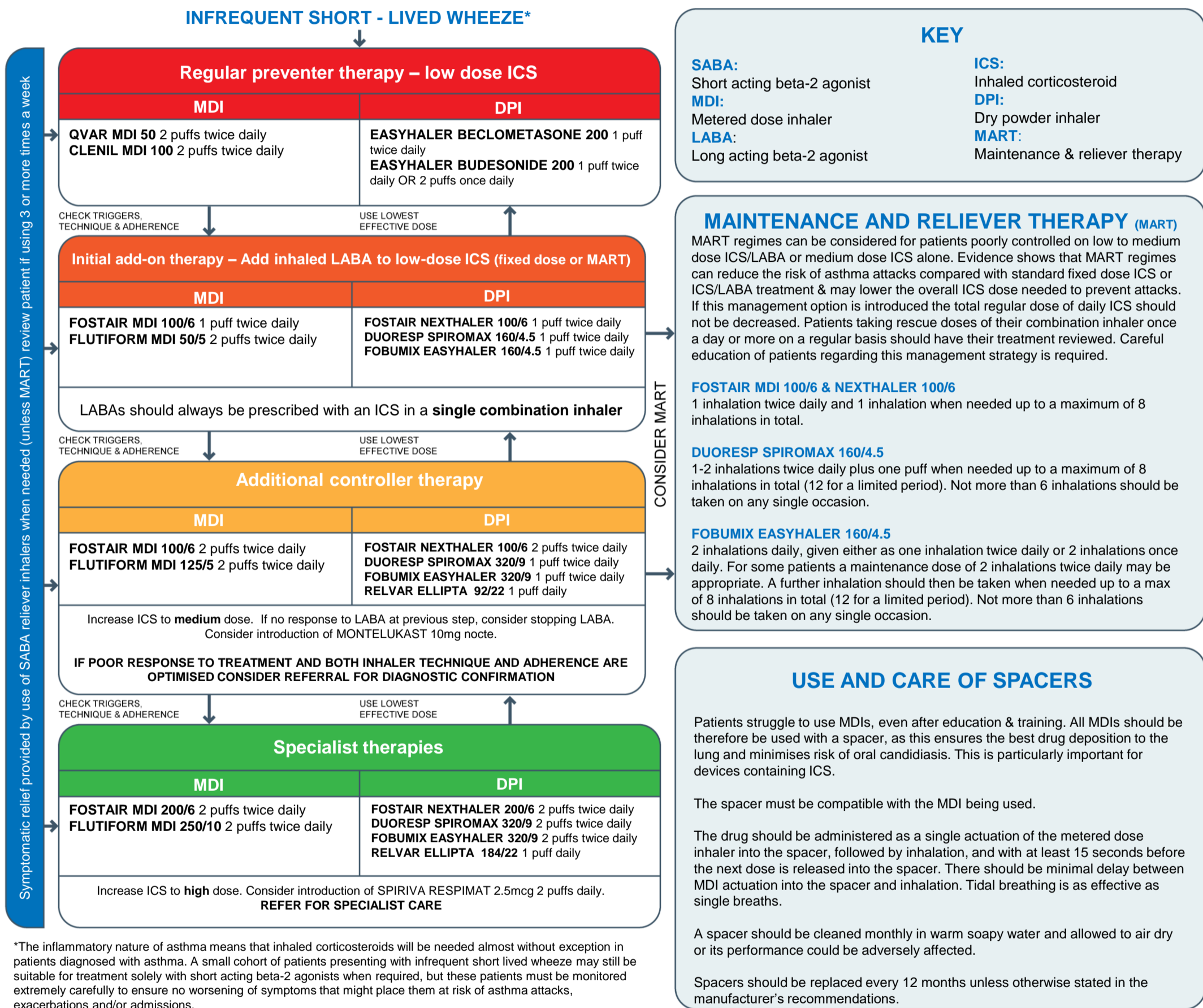


ADULT ASTHMA TREATMENT GUIDELINES (18+YEARS)

This guideline states the **Worcestershire Joint Formulary preferred inhalers**. The intention is to support the choice of treatment for new patients, or patients needing stepping up or down. **Other formulary products and devices are available for prescribing and are listed at: www.worcsformulary.nhs.uk**

Patients currently receiving alternative formulary inhalers should not be routinely switched to these devices unless there are clinical reasons for doing so. A change of device should only take place within a face to face respiratory review.

Prescribers and patients should be aware that there are significant differences in the global-warming potential of different devices and that inhalers with **low** global-warming potential such as DPis listed below should be used when they are likely to be equally effective.



*The inflammatory nature of asthma means that inhaled corticosteroids will be needed almost without exception in patients diagnosed with asthma. A small cohort of patients presenting with infrequent short lived wheeze may still be suitable for treatment solely with short acting beta-2 agonists when required, but these patients must be monitored extremely carefully to ensure no worsening of symptoms that might place them at risk of asthma attacks, exacerbations and/or admissions.

KEY POINTS FOR ASTHMA MANAGEMENT

- A NICE decision aid can be used to facilitate discussions between patients and health care professionals and arrive at an appropriate choice of inhaler: <https://www.nice.org.uk/guidance/ng80/resources/inhalers-for-asthma-patient-decision-aid-pdf-6727144573>
- All inhalers containing ICS can be classified as low, medium or high dose based on the individual drug potency and licensed dose. The lowest effective dose to control symptoms should be used. Review patients regularly to consider stepping up or stepping down according to their level of control. See: https://www.sign.ac.uk/assets/sign158_categorisation_of_inhaled_corticosteroids-adults.pdf for a list of ICS inhaler classifications.
- Check inhaler technique, ICS adherence and trigger avoidance at every opportunity and ALWAYS before changing treatment. Inhaler technique training videos can be found at: www.southworcestershire.nhs.uk/about-us/area-prescribing-committee/how-to-inhaler-guides/
- Prescribe inhalers by **BRAND** to ensure continuity of device for patients.
- Refer patients initiated on new devices to the community pharmacy **New Medication Service (NMS)** to embed technique and understanding.
- When asthma is well controlled, there should be little or no need for a reliever inhaler. Any patient who has been given 6 or more reliever inhalers in six months or 12 or more reliever inhalers in a year should be urgently called in for a review.
- Give a **steroid card** to patients receiving **high dose** ICS. Consider giving a steroid card for patients receiving **medium dose** ICS.
- Refer for specialist opinion if an occupational trigger is suspected.

ICS/LABA INHALER DEVICES



FOSTAIR MDI
(Beclometasone/
formoterol)



FLUTIFORM MDI
(Fluticasone
propionate/formoterol)



RELVAR ELLIPTA DPI
(Fluticasone
furoate/vilanterol)



**DUORESP
SPIROMAX DPI**
(Budesonide/
formoterol)



**FOSTAIR
NEXTHALER DPI**
(Beclometasone/
formoterol)



**FOBUMIX
EASYHALER DPI**
(Budesonide/
formoterol)

ASTHMA REVIEWS

Asthma reviews should take place at least **annually**. The review should include an assessment of current symptom control, an assessment of the future risk of attacks and education/support with self management.

Current level of asthma symptom control. Complete control of asthma is defined as:

- **NO** daytime symptoms
- **NO** need for rescue medications
- **NO** limitation on activity
- **NO** night time awakening
- **NO** exacerbations/attacks
- Normal lung function

With minimal side effects from medication.

Assess control using the 3 Royal College of Physicians (RCP) questions and frequency of SABA use. Check levels of SABA usage over the last 6-12 months to validate response. If positive responses are given, consider further assessment with a validated questionnaire to assess symptom control such as the Asthma Control Test (ACT) – see: <http://www.asthmacontroltest.com/>.

Risk of a future attack. Factors that put an individual at an **increased** risk of an attack are:

- History of previous asthma attacks, including previous use of oral steroids and emergency admissions.
- Poor current symptom control as per above.
- Overuse of reliever medication.
- Older age, female gender, reduced lung function, obesity, smoking and depression.

Education to support self-management. This should include:

- The importance of adherence to long-term asthma treatment. Adherence to controller treatments should be routinely, and regularly, assessed and poor adherence addressed. Consider the usage levels of controller treatments as part of this assessment. Explore attitudes to medication, as well as practical barriers to adherence, in a non-judgemental way.
- An assessment of inhaler technique and corrective action if necessary, including use & cleaning of spacers, if applicable.
- If applicable, advice on weight reduction and smoking cessation.
- Advice on having annual influenza vaccination (unless contraindicated).
- A written personalised asthma action plan (PAAP) should be offered to **all** patients. As a minimum this must include written advice on avoidance of known triggers; how to recognize poor control, **WHEN, WHY** and **HOW** to take inhalers. See: <https://www.asthma.org.uk/advice/manage-your-asthma/action-plan/> for PAAP resources.

STEPPING DOWN ASTHMA TREATMENT

- Safe and effective asthma assessment needs to consider both control of the condition and risk of treatment. High doses of ICS can increase the risk of Type 2 diabetes, cataracts, adrenal suppression and osteoporosis. For this reason, stepping down ICS dose should be considered once complete control (see above) has been established for at least 12 weeks.
- The decision to step down therapy should be jointly made between the clinician and the patient. Reductions should be considered every three months, but only if patients have complete asthma control.
- When reducing ICS clinicians should remember that patients deteriorate at different rates. If asthma is controlled with a combination ICS/LABA inhaler, the preferred approach where possible is to reduce the ICS by approximately 50% whilst continuing the LABA at the same dose. Note that for some combination ICS/LABA devices, stepping down to the licensed lower ICS dose will also reduce the LABA dose.
- Ensure an appropriate time to step down (e.g. avoid allergy seasons for allergic asthma, or stressful times if stress is a known trigger).
- If patient is receiving a high or medium dose ICS, consider respiratory specialist advice on how to manage the step - down process, particularly if a more gradual ICS dose reduction than 50% is required.
- If a patient is under respiratory specialist review, do not attempt step down therapy without the agreement of the specialist.
- **Do not step-down patients who are receiving MART regimes.**
- After stepping down, the patient should be reviewed after 12 weeks.

REFERENCES:

British Thoracic Society. Scottish Intercollegiate Guidelines Network. British guideline on the management of asthma. 2019. <https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/btssign-guideline-for-the-management-of-asthma-2019/>

NICE guideline NG80: Asthma: Diagnosis, monitoring and chronic asthma management. November 2017: <https://www.nice.org.uk/guidance/ng80>