

ASTHMA UPDATE

BY NICOLA STANDRING-BROWN, RN, ACP, QN

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SOUTH YORKSHIRE PRIMARY CARE WORKFORCE AND TRAINING
HUB

ZEPHYR EDUCATION

LEARNING OBJECTIVES



Apply current diagnostic criteria for asthma and distinguish asthma from key differential diagnoses.



Assess asthma severity and level of control using symptom history, risk factors, and objective measures.



Select evidence-based pharmacologic therapy, including stepwise treatment escalation and appropriate inhaler choice.



Incorporate non-pharmacologic management strategies and deliver effective patient education to support self-management.



Manage acute exacerbations and plan appropriate follow-up and monitoring to optimize outcomes.

ASTHMA LATEST FIGURES

7.2 Million people currently living with asthma in the UK
(A+LUK, 2024)

4 deaths from asthma every day in the UK,

2/3 of these are PREVENTABLE

Asthma has a prevalence of 7.4% in Barnsley compared to a national average of 6.6%

Hospital admissions with asthma in Barnsley were 201.8 per 100,000 compared to national average of 138.8 in under 19's

CHANGES TO ASTHMA CARE

Recognition of SABA overuse as a risk factor for exacerbation and death.

New UK guidelines (BTS/NICE/SIGN)

New South Yorkshire wide guidelines for Adult Asthma

New South Yorkshire wide guidelines for Children's Asthma

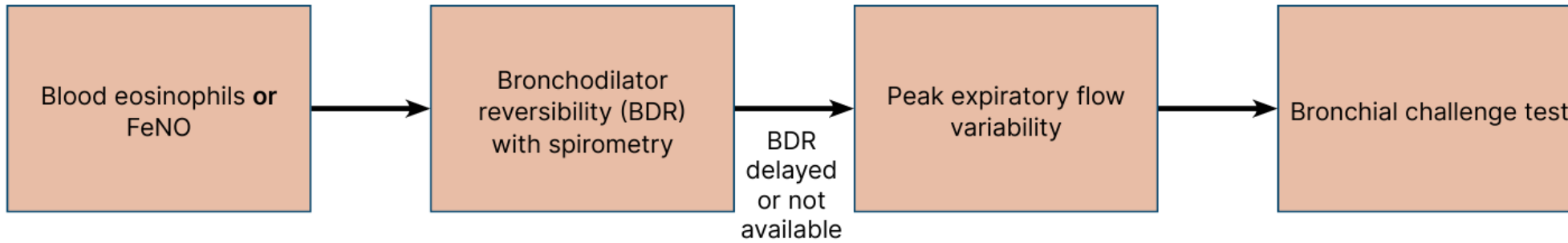
Recommendations on core capability training for those working with children's asthma (NHSE)

ASTHMA DIAGNOSIS

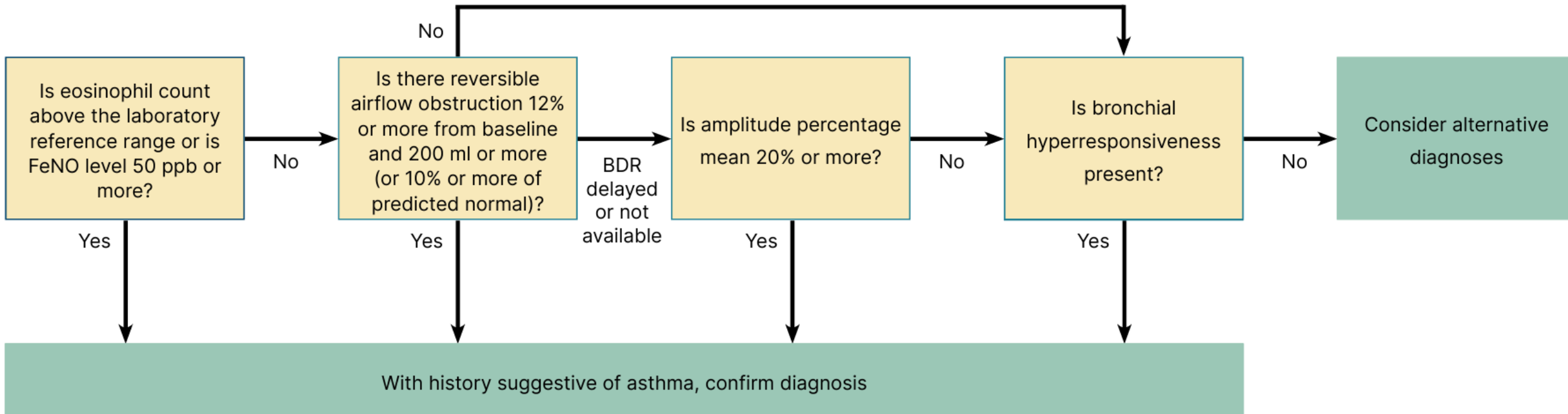
Obtain a structured clinical history in people with suspected asthma. Specifically, check for:

- reported wheeze, noisy breathing, cough, breathlessness or chest tightness, and any variation (for example, worse during the night or early morning, or seasonal) in these symptoms
- any triggers that make symptoms worse
- a personal or family history of asthma or allergic rhinitis
- symptoms to suggest alternative diagnoses

Examination: Allergic rhinitis, expiratory polyphonic wheeze, chest wall changes



Interpretation of test results



OBJECTIVE TESTING IN ADULTS

AIR AND MART

AIR – Anti-inflammatory reliever:

Used for very occasional symptoms.

Replaces SABA only.

Seamlessly transitions to MART.

MART – Maintenance and reliever therapy:

Flexible regime where fixed doses (maintenance) provide a good level of control and occasional extra puffs support (replacing the need for SABA)

BOTH can be used in an emergency. 6 Puffs initially and repeat.

CASE STUDY- SARAH, 23 YEARS OLD

Sarah attends an appointment with you because she has experienced:

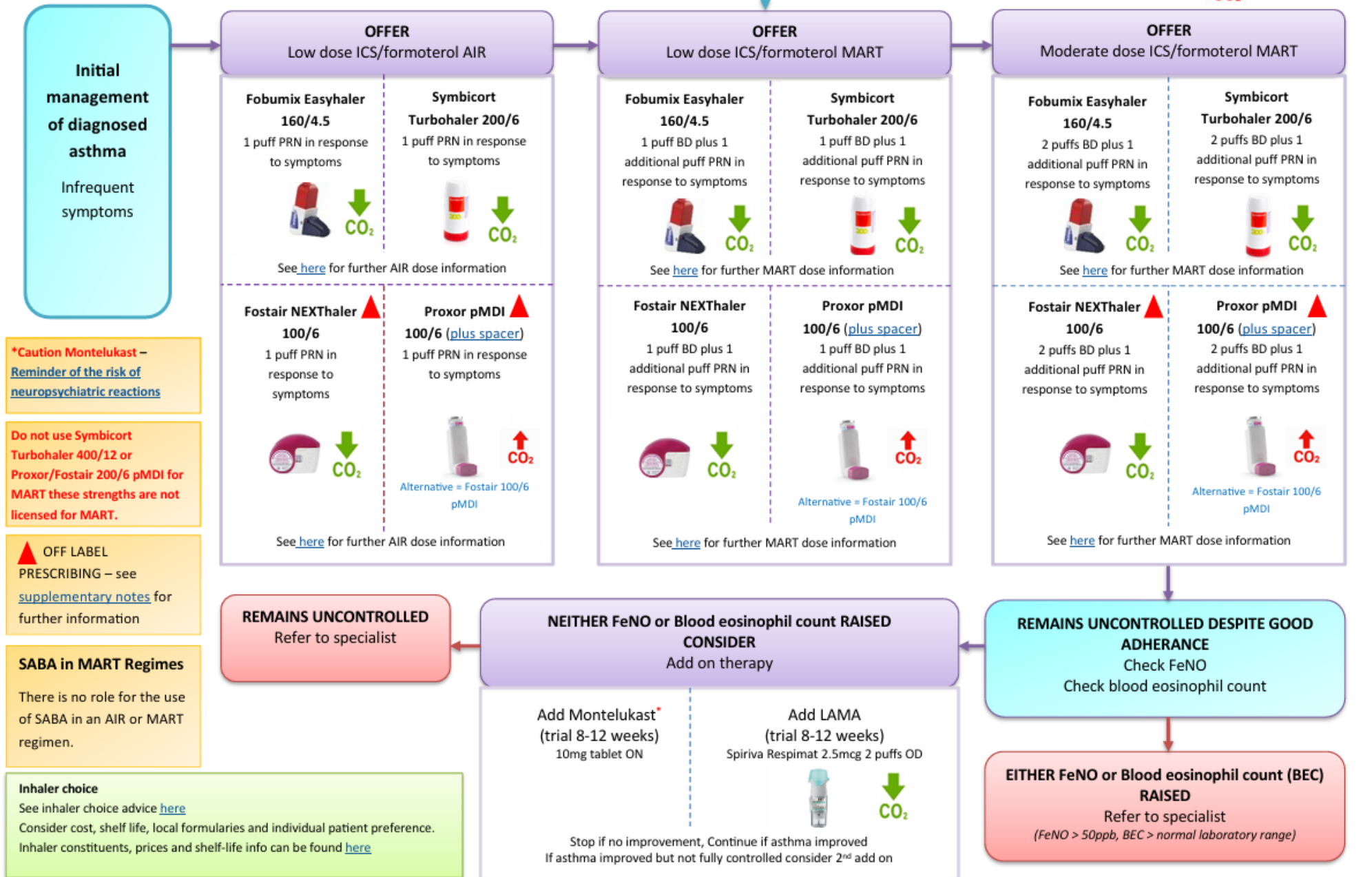
- Intermittent chest tightness when around cats
- Occasional wheeze
- Symptoms worse when running and during cold weather
- Waking once or twice a month with symptoms
- Symptoms vary from day to day
- Inhalers as a child

What tests? What treatment?



ASTHMA TREAT- MENT IN ADULTS

Adults 18+ AIR and MART Pathway



Guidance on managing asthma if AIR/MART is not suitable

Always try AIR/MART pathway first line. Discuss benefits of AIR/MART (safer, reduced exacerbations, reduced mortality), discuss concerns (some people worry if they can't feel the inhaler that it is not working). Some situations where AIR/MART may not be appropriate may include; cannot tolerate formoterol, cannot use a DPI, cannot manage flexible dosing. If after trying AIR/MART it is deemed unsuitable, clearly document reason in patient notes and consider a fixed dose regime. **Reconsider AIR/MART at every review and at least annually.**

SABA alone must not be used.

Low dose ICS	Low dose ICS/LABA	Moderate dose ICS/LABA	Add on therapy	
<p>Easyhaler Budesonide 100 or 200mcg 1 puff BD</p> <p>Pulmicort Turbohaler 100 or 200 1 puff BD</p>	<p>Fobumix Easyhaler 160/4.5 1 puff BD</p> <p>Fostair NEXThaler 100/6 1 puff BD</p> <p>Symbicort Turbohaler 200/6 1 puff BD</p> <p>Relvar Ellipta 92/22 mcg 1 puff OD</p>	<p>Fobumix Easyhaler 320/9 1 puff BD</p> <p>Fostair NEXThaler 100/6 2 puffs BD</p> <p>Symbicort Turbohaler 400/12 1 puff BD</p> <p>Relvar Ellipta 92/22 mcg 1 puff OD</p>	<p>Check FeNO/BEC - If either raised – consider referral to specialist</p> <p>Consider adding montelukast 10mg tablet ON (Trial 8-12 weeks - Stop if no improvement, continue if asthma improved. If asthma improved but not fully controlled consider 2nd add on)</p> <p>Or add Spiriva Respimat 2.5mcg (Trial 8-12 weeks - Stop if no improvement, continue if asthma improved. If asthma improved but not fully controlled consider 2nd add on)</p> <p>Or Consider single inhaler triple therapy inhaler (see below)</p>	<p>Remains uncontrolled - Refer</p> <p>Any patient on high dose ICS - refer</p>
<p>Soprobeq 100 or 200 pMDI 1 puff BD</p> <p>Alternative = Clenil 100 or 200</p>	<p>Proxor 100/6 pMDI 1 puff BD</p> <p>Alternative = Fostair 100/6 pMDI</p>	<p>Proxor 200/6 pMDI 1 puff BD</p> <p>Alternative = Fostair 200/6 pMDI</p>		

Plus SABA PRN – Easyhaler Salbutamol 100mcg or Salamol pMDI 100mcg

Always prescribe pMDIs with a [spacer](#)

Fixed dose single inhaler triple therapy (ICS/LABA/LAMA) + SABA

	Moderate Dose Triple Therapy	High dose Triple Therapy
<p>Triple therapy should only be initiated by a clinician with an asthma qualification and appropriate experience</p> <p>MART should always be considered first line</p> <p>Fixed dose triple therapy should only be considered after comprehensive review by a clinician with expertise in asthma</p> <p>Indication for fixed dose triple should be clearly documented in patient's notes</p>	<p>Trimbow pMDI 87/5/9 (plus spacer) 2 puffs BD</p>	<p>Trimbow NEXThaler 88/5/9 2 puffs BD</p>

 OFF LABEL PRESCRIBING – see [supplementary notes](#) for further information

Always try AIR/MART pathway first line. Discuss benefits of AIR/MART (safer, reduced exacerbations, reduced mortality), discuss concerns (some people worry if they can't feel the inhaler that it is not working). Some situations where AIR/MART may not be appropriate may include; cannot tolerate formoterol, cannot use a DPI, cannot manage flexible dosing. If after trying AIR/MART it is deemed unsuitable, clearly document reason in patient notes and consider a fixed dose regime. **Reconsider AIR/MART at every review and at least annually.**

SABA alone must not be used.

Low dose ICS

Easyhaler Budesonide
100 or 200mcg
1 puff BD

Pulmicort Turbohaler
100 or 200
1 puff BD

Soprobe 100 or 200 pMDI
1 puff BD 
Alternative = Clenil 100 or 200

Low dose ICS/LABA

Fobumix Easyhaler 160/4.5
1 puff BD
Fostair NEXThaler 100/6
1 puff BD
Symbicort Turbohaler 200/6
1 puff BD
Relvar Ellipta 92/22 mcg
1 puff OD

Proxor 100/6 pMDI
1 puff BD
Alternative = Fostair 100/6 pMDI

Moderate dose ICS/LABA

Fobumix Easyhaler 320/9
1 puff BD
Fostair NEXThaler 100/6
2 puffs BD
Symbicort Turbohaler 400/12
1 puff BD
Relvar Ellipta 92/22 mcg
1 puff OD

Proxor 200/6 pMDI
1 puff BD
Alternative = Fostair 200/6 pMDI

Add on therapy

Check FeNO/BEC - If either raised – consider referral to specialist

Consider adding montelukast 10mg tablet ON
(Trial 8-12 weeks - Stop if no improvement, continue if asthma improved.
If asthma improved but not fully controlled consider 2nd add on)

Or add
Spiriva Respimat 2.5mcg
(Trial 8-12 weeks - Stop if no improvement, continue if asthma improved.
If asthma improved but not fully controlled consider 2nd add on)

Or
Consider single inhaler triple therapy inhaler ([see below](#))

**Remains
uncontrolled -
Refer**

**Any patient
on high dose
ICS - refer**

Plus SABA PRN – Easyhaler Salbutamol 100mcg or Salamol pMDI 100mcg

Always prescribe
pMDIs with a spacer

Fixed dose single inhaler triple therapy (ICS/LABA/LAMA) + SABA

Triple therapy should only be initiated by a clinician with an asthma qualification and appropriate experience

MART should always be considered first line

Fixed dose triple therapy should only be considered after comprehensive review by a clinician with expertise in asthma

Indication for fixed dose triple should be clearly documented in patient's notes

Moderate Dose Triple Therapy

Trimbow pMDI
87/5/9 (plus [spacer](#))
2 puffs BD

**Trimbow NEXThaler**

88/5/9
2 puffs BD



High dose Triple Therapy

Refer all patients on high dose ICS/LABA/LAMA to secondary care

▲ OFF LABEL PRESCRIBING – see [supplementary notes](#) for further information

ASTHMA DIAGNOSIS AND MANAGEMENT IN CHILDREN AND YOUNG PEOPLE

ASTHMA IN CHILDREN AND YOUNG PEOPLE - NCMD 2024

April 2019 and 31 March 2023 1 death every 4 weeks (54)

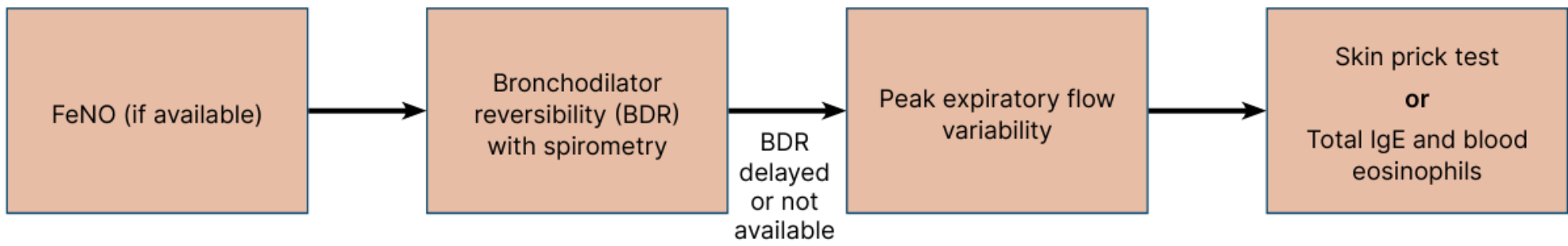
Death rates were highest in 15 – 17-year-olds

The death rate of boys (1.53 per 1 million children) was more than double that of girls

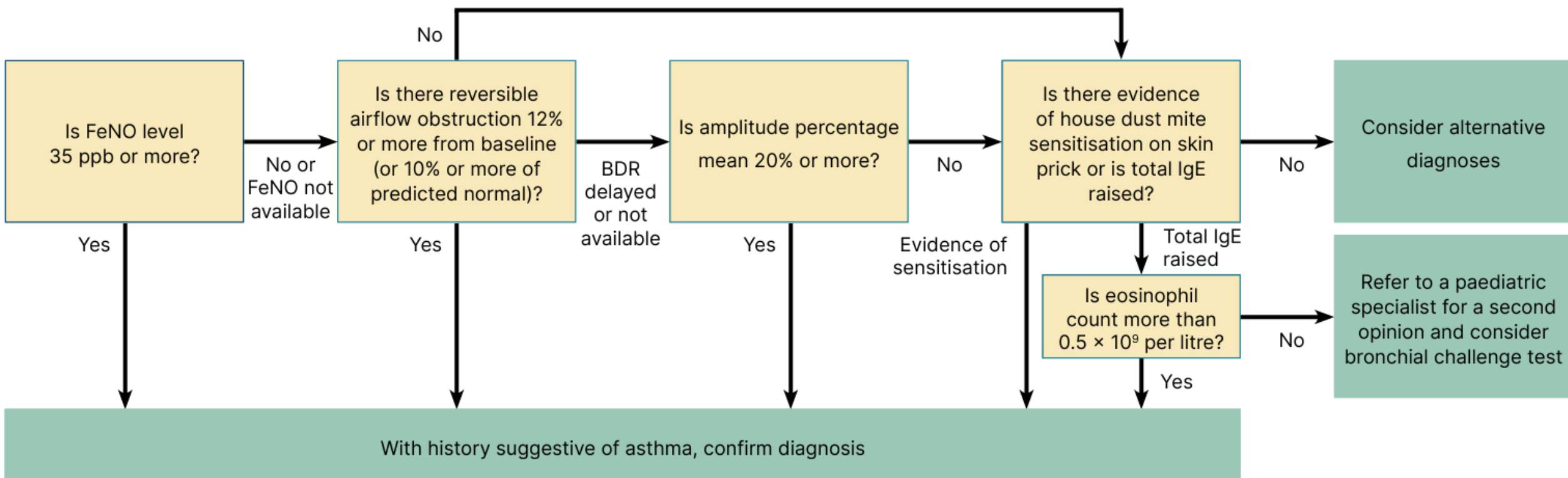
The death rate was higher for children living in urban area

The death rate was four times higher for children living in the most deprived neighbourhoods of England

Children living in the poorest 10% of areas were four times more likely to have an emergency hospital admission than those in the least deprived 10%

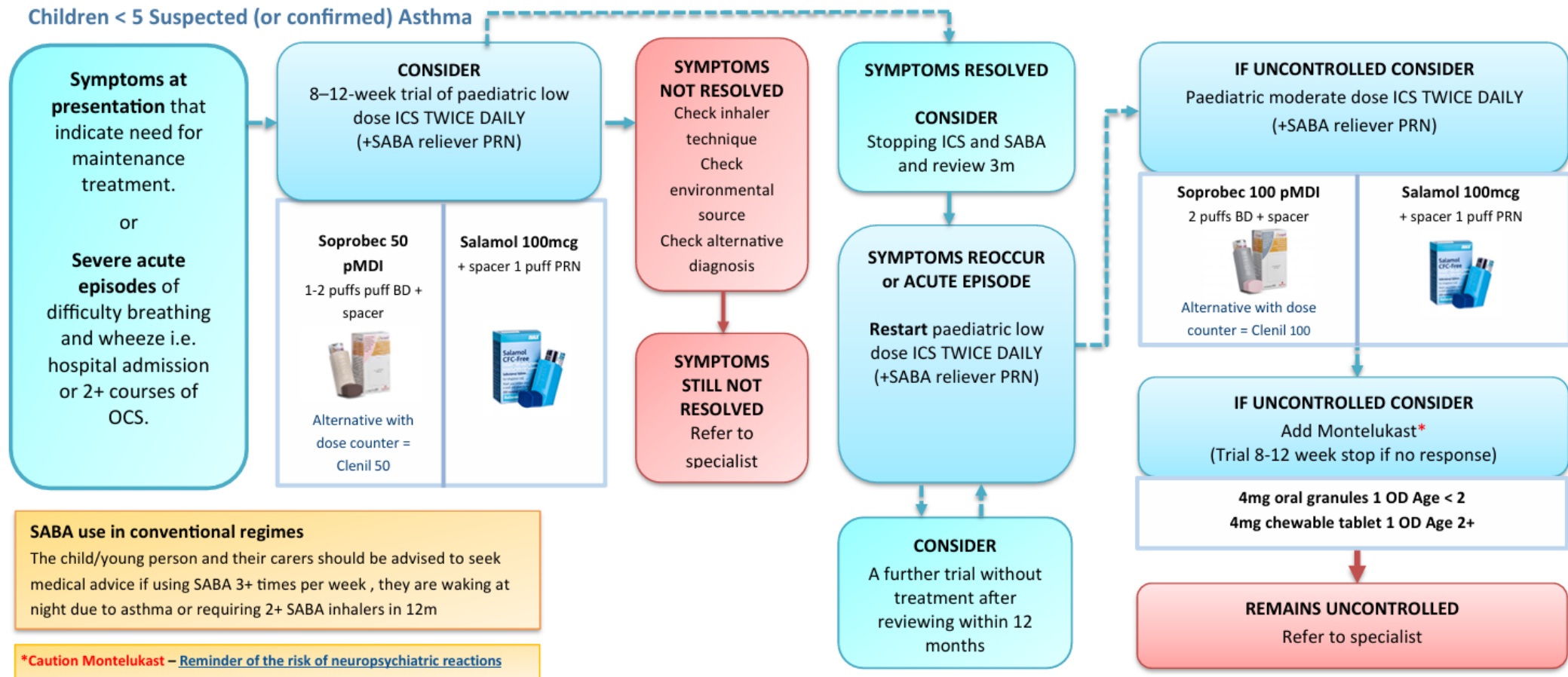


Interpretation of test results



UNDER 5'S

- Preschool wheeze is common occurring in up to one third of preschool children.
- Objective tests are hard to complete and good reference ranges aren't available.
- Approach:
 - Confirm wheeze
 - Exclude other causes
 - Is it episodic or recurrent?
 - 2 or more episodes with confirmed wheeze
 - Interval symptoms
 - Responds to treatment with ICS



TREATMENT OF ASTHMA IN CHILDREN UNDER 5

CASE EXAMPLE

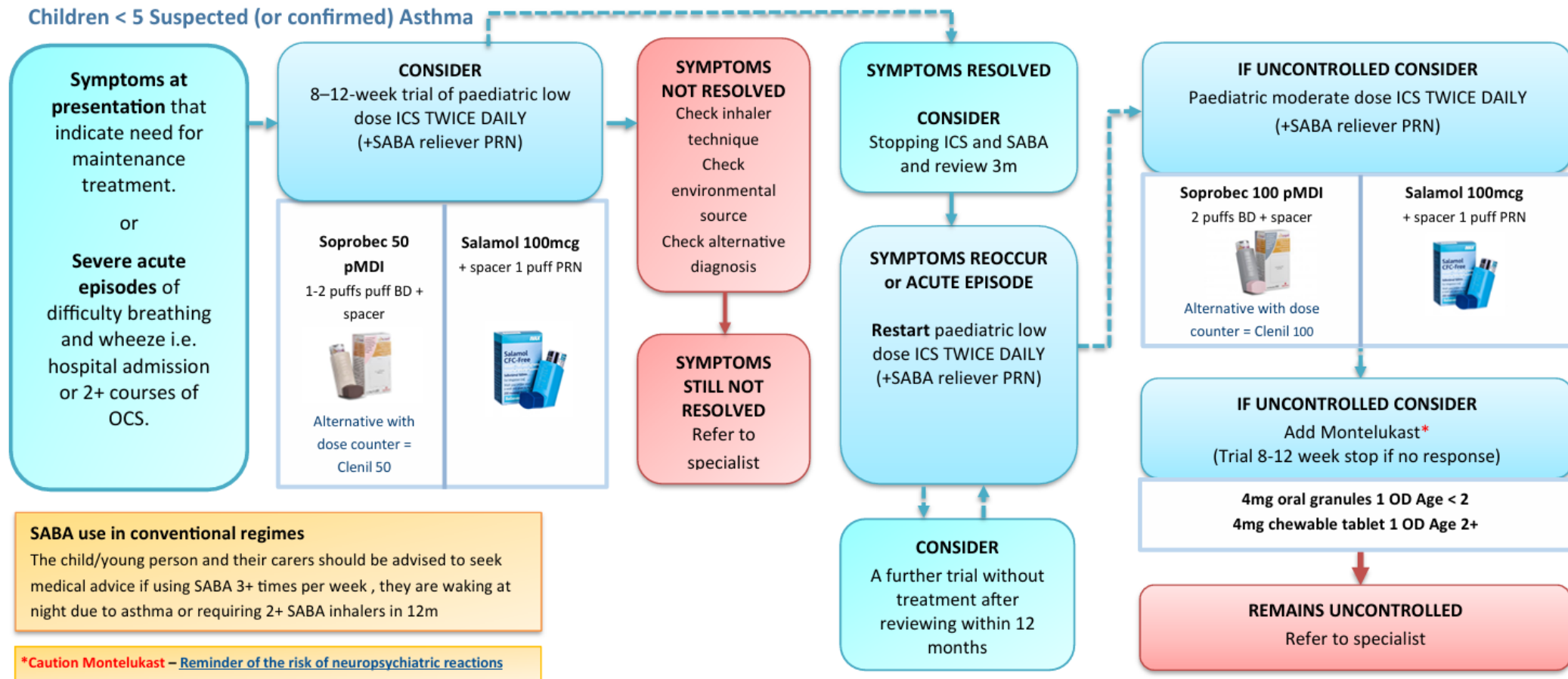
Alisha comes to see you with her mum

Mum is worried because Alisha needed to attend A+E last week with difficulty breathing, dry cough and wheeze

Alisha has been prone to a cough in the night the last few months and always gets a bit wheezy when the pollen count is high

What will you do for Alisha?

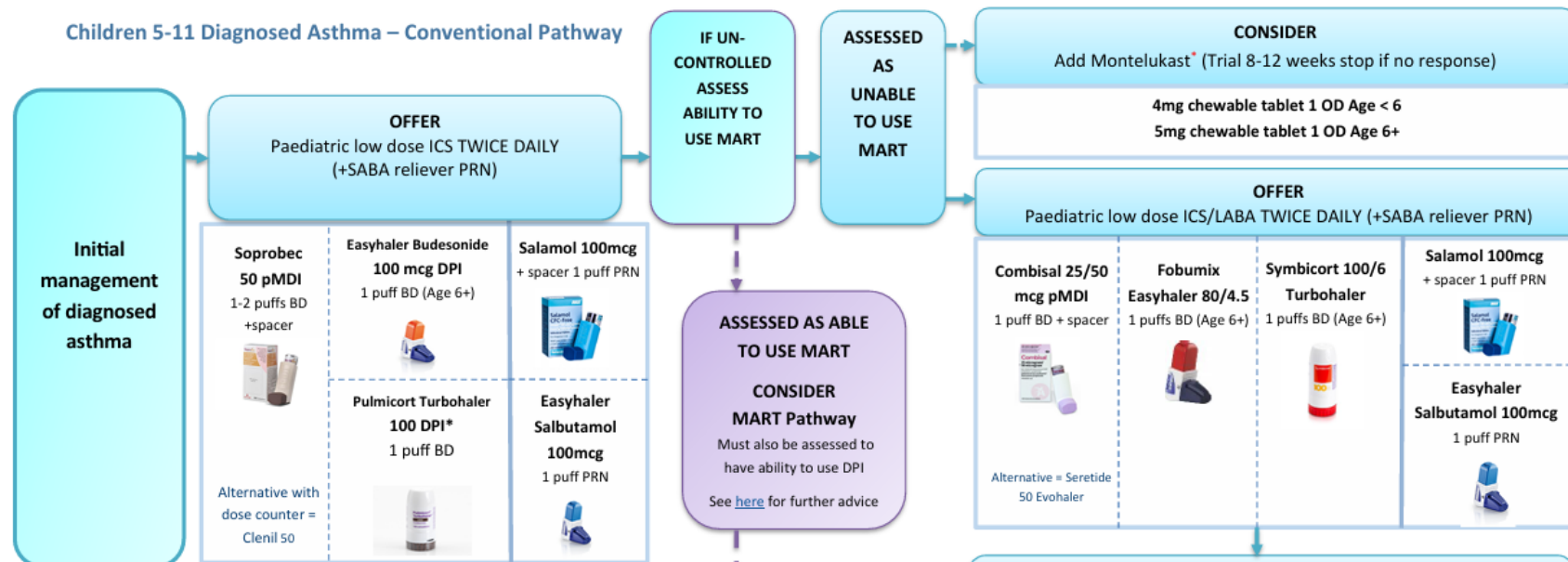




TREATMENT OF ASTHMA IN CHILDREN UNDER 5

ASTHMA TREATMENT IN CHILDREN 5-11

Children 5-11 Diagnosed Asthma – Conventional Pathway



Children 5-11 Diagnosed Asthma – MART Pathway

SABA in MART Regimes

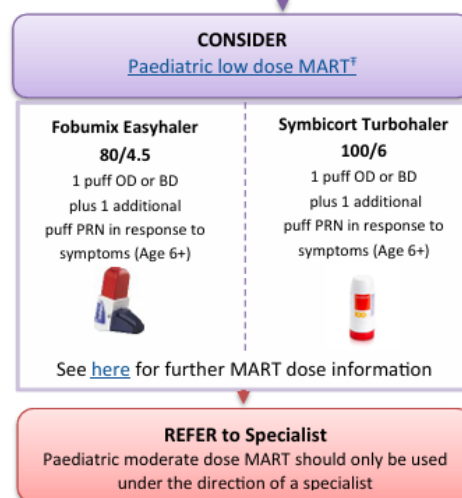
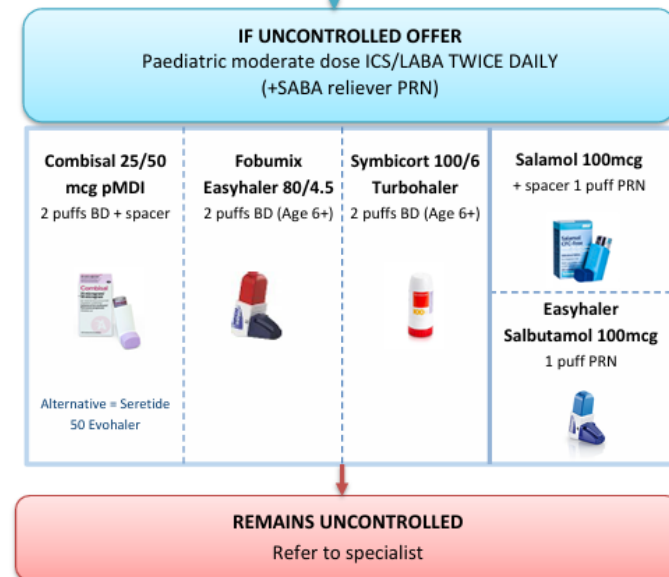
There is no role for the use of SABA in an AIR or MART regime. The one exception to this is if the child/young person is in a situation where their MART inhaler is not available (e.g. in school). Treatment should be with their SABA in a conventional way.

†Only Symbicort Turbohaler 100/6 has a MART licence in this age group (6+). Use of other devices is currently off label in this age group. The decision to use the device off label must be made in collaboration with the family/young person based on an informed discussion. Where licensed options become available, these should be used in preference.

See [here](#) for further information on the prescribing of MART regimes for children aged 5-11.

*Caution Montelukast – Reminder of the risk of neuropsychiatric reactions

MART = Maintenance and Reliever Therapy



CASE EXAMPLE

Ben is 8, he has a classic history of asthma and a normal respiratory examination today.

He had inhalers for asthma started when he was 4, but he stopped them about a year ago aside from very occasional use.

Dad asks if he has grown out of it, but you can hear from history taking he has symptoms in-keeping with asthma most weeks.

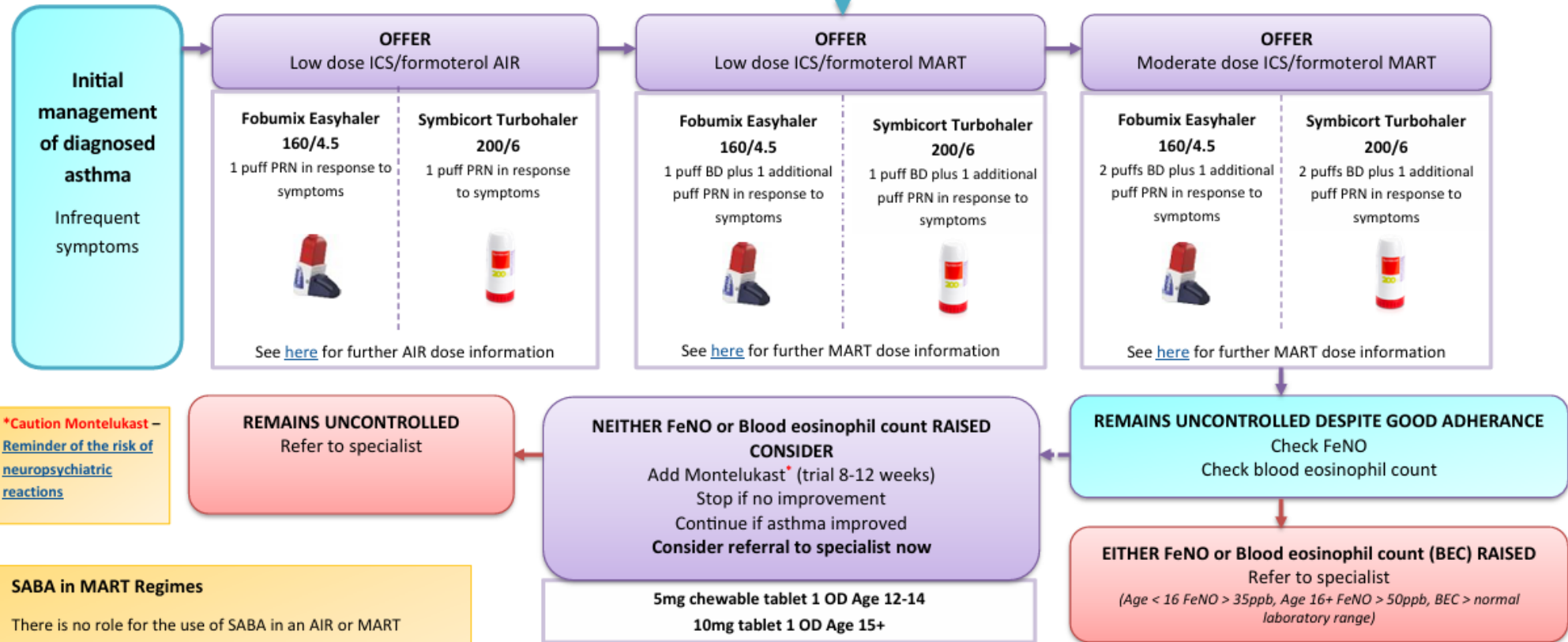
What tests? What treatment?



AIR AND MART 12-17'S

Adolescents 12-17 AIR and MART Pathway

If highly symptomatic at presentation start here
in addition to treating acute symptoms as indicated i.e. with OCS



SABA in MART Regimes

There is no role for the use of SABA in an AIR or MART regime. The one exception to this is if the child/young person is in a situation where their MART inhaler is not available (e.g. in school). Treatment should be with their SABA in a conventional way.

Treatment Pathways for Adolescents 12-17

[NICE/BTS/SIGN 2024 Asthma guidelines](#) do not recommend an alternative treatment pathway for adolescents 12-17. In South Yorkshire we agree that AIR/MART should be the pathway of choice for patients in this age group however we understand that for a small minority of patients this pathway may not be suitable. See right for further advice

Guidance on managing CYP age 12-17 if AIR/MART is not suitable

Always try AIR/MART pathway first line. Discuss benefits of AIR/MART (safer, reduced exacerbations, reduced mortality), discuss concerns (some people worry if they can't feel the inhaler that it is not working). Some situations where AIR/MART may not be appropriate may include cannot tolerate formoterol, cannot use a DPI, cannot manage flexible dosing. If after trying AIR/MART it is deemed unsuitable, document reason in patient notes and consider a fixed dose regime. **Reconsider AIR/MART at every review and at least annually. SABA alone must not be used.**

Low dose ICS	Low dose ICS/LABA	Moderate dose ICS/LABA	Add on therapy/Referral
Soprobe 100 or 200 1 puff BD Easyhaler Budesonide 100 or 200 mcg 1 puff BD Pulmicort Turbohaler 100 or 200 1 puff BD	Combisal 25/50 mcg 2 puffs BD Fobumix Easyhaler 160/4.5 1 puff BD Symbicort Turbohaler 200/6 1 puff BD Relvar Ellipta 92/22mcg 1 puff OD	Combisal 25/125 2 puffs BD Fobumix Easyhaler 320/9 1 puff BD Symbicort Turbohaler 400/12 1 puff BD Relvar Ellipta 92/22 mcg 1 puff OD	Check FeNO/BEC If either raised – Refer to specialist If neither raised - consider adding montelukast 5mg chewable tablet OD Age 12-14 10mg tablet OD Age 15+ (Trial 8-12 weeks stop if no response) Remains uncontrolled – Refer
Plus SABA PRN – Salamol 100mcg or Easyhaler Salbutamol 100mcg	Plus SABA PRN – Salamol 100mcg or Easyhaler Salbutamol 100 mcg	Plus SABA PRN – Salamol 100 mcg or Easyhaler Salbutamol 100mcg	

CASE EXAMPLE



Grace is 14, she has an existing asthma diagnosis confirmed with FeNO (40ppb) from a few years ago.

At her review she is resistant to the idea of using a regular preventer as she rarely has symptoms and does not want to be embarrassed by taking inhalers. She has been on combisal 25/50mcg 2pBD although she does not request it from practice and a Salbutamol.

What treatment could you offer?

MART AND AIR AT A GLANCE

AIR and MART 12-17 Important Information

	Inhaler	Daily Maintenance Dose	Additional doses	Total daily maximum doses (including maintenance doses)	When to seek medical advice	Additional information
AIR	Budesonide/formoterol DPI Fobumix Easyhaler 160/4.5 Symbicort Turbohaler 200/6	None	1 inhalation as needed in response to symptoms. If symptoms persist after a few minutes an additional inhalation should be taken. Not more than 6 inhalations should be taken on any one occasion	A total daily dose of more than 8 inhalations is not normally needed. However, a total daily dose of up to 12 inhalations could be used for 2 days. See also Emergency Management	CYP requiring 8 inhalations in a day should be strongly recommended to seek medical advice. Children should be advised to seek a non-urgent review if needing their AIR inhaler 3 + times a week	You may wish to set an issue duration of approximately 60-90 days per inhaler to prompt if inhalers are being ordered more frequently than expected. Stop regular SABA on repeat. See SABA in MART regimes
Low dose MART	Budesonide/formoterol DPI Fobumix Easyhaler 160/4.5 Symbicort Turbohaler 200/6 <small>Budesonide/formoterol 100/6 (80/4.5) DPI is also licensed for MART with the same doses where a lower overall steroid dose is preferable.</small>	1 inhalation TWICE a day (or 2 inhalations ONCE a day)	1 puff as needed in response to symptoms. If symptoms persist after a few minutes an additional inhalation should be taken. Not more than 6 inhalations should be taken on any one occasion	A total daily dose of more than 8 inhalations is not normally needed. However, a total daily dose of up to 12 inhalations could be used for a limited period See also Emergency Management	Children requiring 8 inhalations in a day should be strongly recommended to seek medical advice. Children should be advised to seek a non-urgent review if needing their AIR inhaler 3 + times a week	You may wish to set an issue duration of approximately 45 days per inhaler to prompt if inhalers are being ordered more frequently than expected. Stop regular SABA on repeat. See SABA in MART regimes
Moderate dose MART	Budesonide/formoterol DPI Fobumix Easyhaler 160/4.5 Symbicort Turbohaler 200/6	2 inhalations TWICE a day	1 puff as needed in response to symptoms. If symptoms persist after a few minutes an additional inhalation should be taken. Not more than 6 inhalations should be taken on any one occasion	A total daily dose of more than 8 inhalations is not normally needed. However, a total daily dose of up to 12 inhalations could be used for a limited period See also Emergency Management	Children requiring 8 inhalations in a day should be strongly recommended to seek medical advice. Children should be advised to seek a non-urgent review if needing their AIR inhaler 3 + times a week	You may wish to set an issue duration of approximately 18 days per inhaler to prompt if inhalers are being ordered more frequently than expected. Stop regular SABA on repeat. See SABA in MART regimes

NEW ASTHMA PATHWAY FOR CHILDREN IN BARNESLEY



QUESTIONS?



COPD UPDATE

BY NICOLA STANDRING-BROWN, RN, ACP, QN

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LEARNING OBJECTIVES

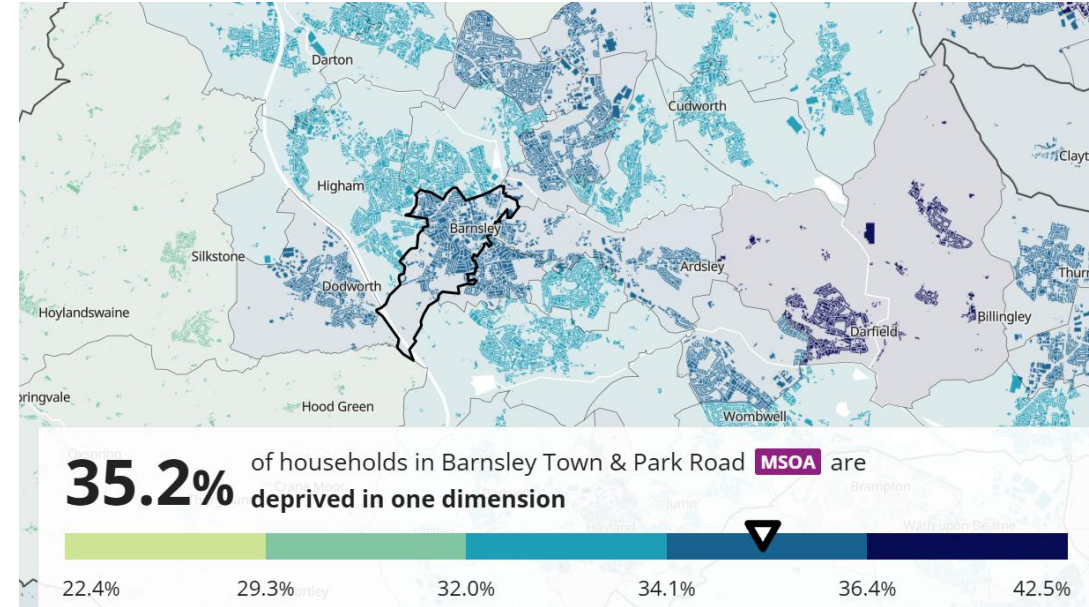
- 01 Recognise the latest evidence-based approach to diagnosing and assessing COPD severity.
- 02 Review current pharmacological treatment options, including when to escalate or de-escalate inhaled therapy.
- 03 Apply updates on non-pharmacological management such as smoking cessation, pulmonary rehabilitation, vaccination, and self-management support.
- 04 Identify how to prevent and manage acute exacerbations, including follow-up after hospital admission.
- 05 Integrate a multidisciplinary, patient-centred approach for long-term monitoring and optimisation of care.

COPD IN BARNSELY

COPD prevalence sits at 3.4% in 2024/25 in Barnsley compared to a national average of 1.9%

Deaths from COPD in Barnsley are 153.1 per 100,000 compared to a national average of 101.7.

Data from [Fingertips.phe.org.uk](https://fingertips.phe.org.uk)



Poor respiratory health plays a key role in driving health inequalities, a crucial area of focus for the NHS.

In South Yorkshire, 36.7% of neighbourhoods were in the fifth most deprived of neighbourhoods nationally.

WHAT'S NEW IN COPD?

Increased understanding of impact on cardiovascular system.

Greater consideration of exacerbation prevention.

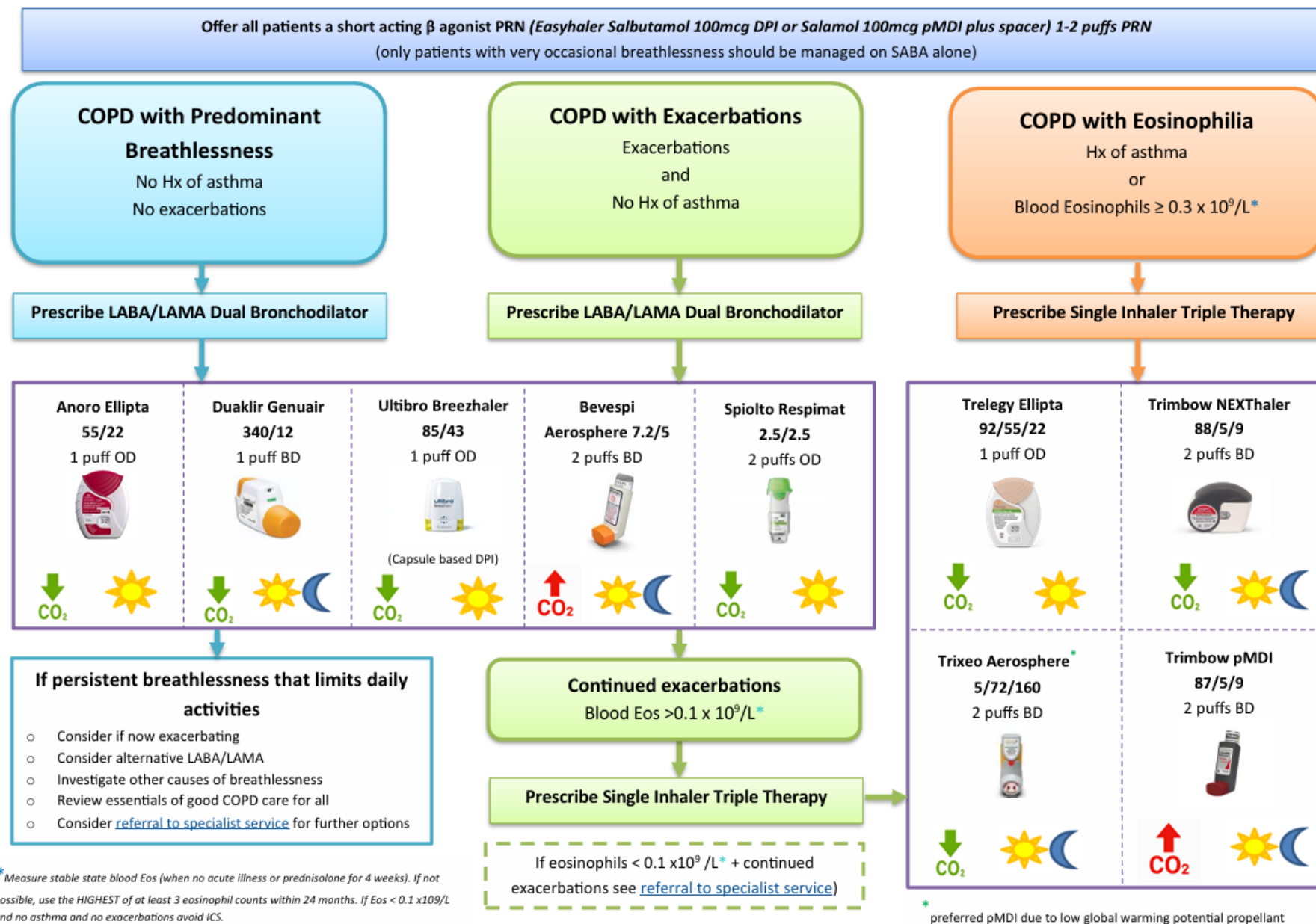
Specific focus on mind, bones and heart in COPD treatment.

Biologic therapies added to treatment options.

DIAGNOSIS



- COPD diagnosis is done by good structured clinical history including occupation, symptoms, family and smoking history.
- Examination should look for:
 - Chest hyperinflation
 - Finger clubbing
 - Accessory muscle use
 - Breathlessness
 - Cough
 - Wheeze
 - Cachexia
- Diagnosis is confirmed by spirometry. – FEV1/FVC Ratio less than 70% (GLI/GOLD Consensus document 2026)



CASE EXAMPLE

Gill has been diagnosed newly with COPD her FEV1 is 60% predicted, her blood eosinophils are $0.35 \times 10^9/L$

You have explained the diagnosis and now are moving on to a discussion about management.

What will you offer/advise?



HEARTS, MINDS AND BONES



RELATIVE RISK OF CARDIOVASCULAR EVENTS POST- COPD EXACERBATION

COPD Exacerbations Independently
Trigger Acute MI and Ischemic Stroke
Dose-response risk increases over a 91-
day vulnerable window (*Rothnie et al.,
AJRCCM 2018*)

- **The Vulnerable Period:** Respiratory flare-ups cause systemic inflammation and vascular strain, driving acute events for **up to 3 months**.

Moderate Exacerbation Risk

Myocardial Infarction: **1.58x** increased risk (IRR 1.58; 95% CI: 1.46–1.71)

Ischemic Stroke: **1.45x** increased risk (IRR 1.45; 95% CI: 1.33–1.57)

Severe Exacerbation Risk

Myocardial Infarction: **2.58x** increased risk (IRR 2.58; 95% CI: 2.26–2.95)

Ischemic Stroke: **1.97x** increased risk (IRR 1.97; 95% CI: 1.66–2.33)

THE ACUTE BURDEN: FRONT-LOADED POST-EXACERBATION MORTALITY

The First Week Peak:

Absolute mortality reaches **40 deaths per 10,000 person-days** immediately following a hospitalised COPD exacerbation.

The 3-Month Plateau: It takes **90 days** for absolute mortality to return to the stable **baseline of 5 deaths per 10,000 person-days**.

The 8-Fold Increase: This represents **an 8x spike** compared to the stable COPD baseline rate.



MODIFYING EXACERBATION RISK

The risk of exacerbations is significantly increased among people with:

- Higher symptom burden (dyspnoea, chronic bronchitis)
- Raised blood eosinophils
- History of past exacerbations
- Certain comorbidities (e.g. GORD and CV disease)

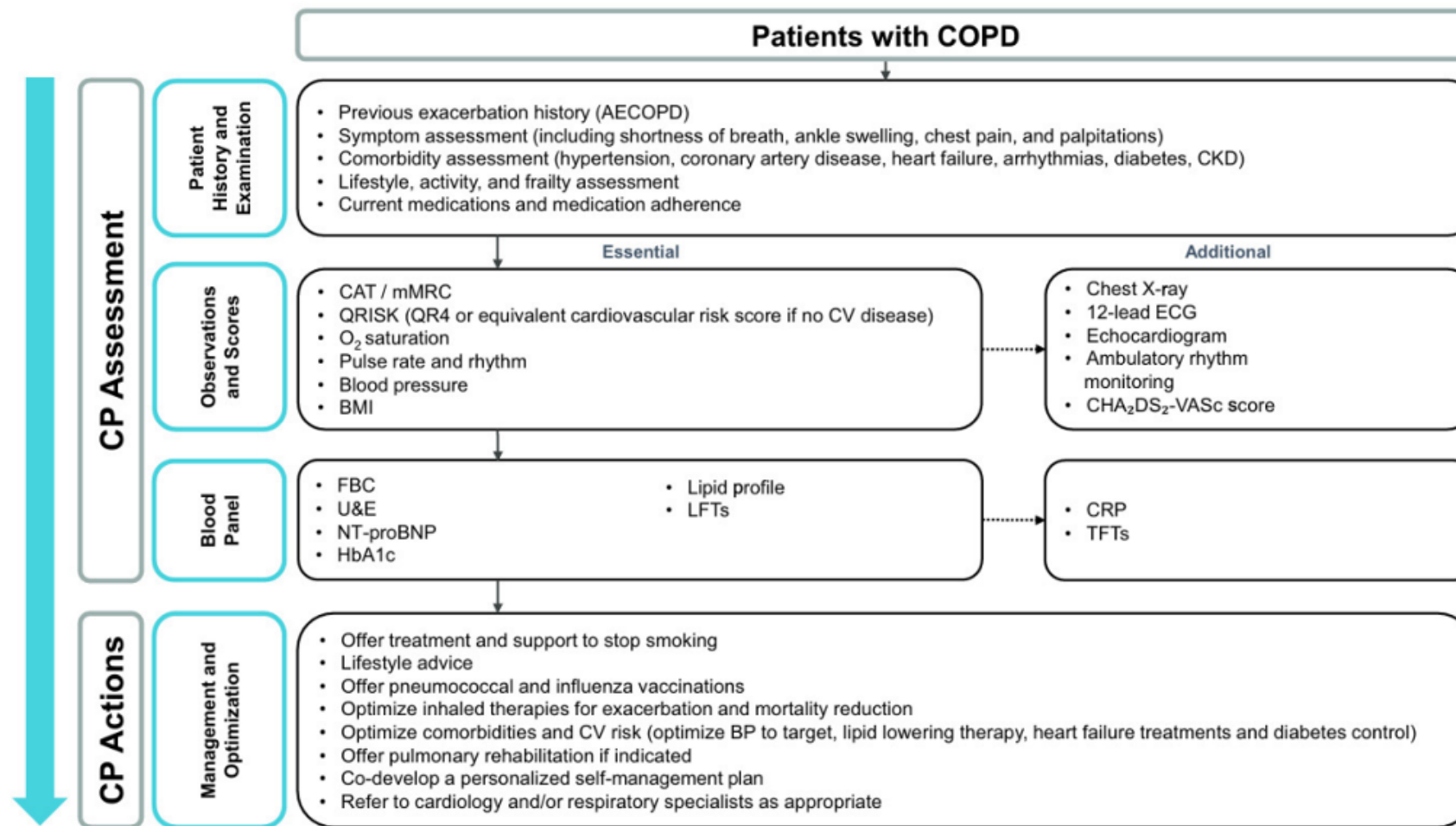
- Single inhaled triple therapy (SITT) is recommended for people with a past history of exacerbations and blood eosinophils $\geq 0.3 \times 10^9/L$
- People with blood eosinophils between 0.1 and $0.3 \times 10^9/L$ are likely to benefit from SITT but decision to treat should be balanced against pneumonia risk

STRONGLY FAVOURS USE ¹
<ul style="list-style-type: none"> • History of hospitalisation(s) for exacerbations of COPD* • ≥ 2 moderate exacerbations of COPD per year* • Blood eosinophils ≥ 300 cells/μL • History of, or concomitant asthma
FAVOURS USE ¹
<ul style="list-style-type: none"> • 1 moderate exacerbation of COPD per year* • Blood eosinophils 100 to <300 cells/μL
AGAINST USE ¹
<ul style="list-style-type: none"> • Repeated pneumonia events • Blood eosinophils <100 cells/μL • History of mycobacterial infection

SINGLE INHALED TRIPLE THERAPY

Optimising Cardio-pulmonary Risk in COPD

Patients with COPD are at a higher risk of hypertension, atrial fibrillation (AF), heart failure (HF), coronary artery disease (CAD), peripheral vascular disease (PVD) and stroke. COPD is a major risk factor for cardiovascular mortality. Screening for hypertension, AF, HF, CAD, PVD can be incorporated into a COPD review. The cardio-pulmonary (CP) risk assessment matrix below has been developed to support the implementation of CP risk assessment in COPD patients. Consider using this tool during COPD reviews where appropriate to assess CP risk and support CP optimisation. See [here](#) for further information.



MENTAL HEALTH

- People with COPD have a high prevalence of anxiety and depression which can contribute to their symptom burden. Anxiety and depression are often under recognised and diagnosed in people with COPD.
- Potential co-morbid anxiety and depression should be considered in all patients with COPD.
- Depression in COPD should be treated the same as for people without COPD.
- Consider:

Psychological interventions - refer to Talking Therapies

Social Prescribing

Drug treatment

Pulmonary rehabilitation



SMOKING CESSATION AND PULMONARY REHABILITATION

- Offer tobacco dependence support to those who smoke.
- Encourage Quit attempts.
- Consider completing NCSCT online modules



SCOPES Tool - COPD

Developed by the South East Act on COPD forum

To be used when optimising a COPD patient either at annual review or post-exacerbation

☒ *At risk of COPD exacerbation		☐ *COPD follow-up
COPD acute exacerbation		☐
S - Smoking Cessation	Smoking	<input type="text"/>
	Cessation advice	<input type="text"/>
C - CVD Risk & Comorbidities	CVD Risk	<input type="text"/>
	H/O: CVD	☐ ☒ <input type="text"/>
☒ PHQ-2 & PHQ-9		☒ GAD Scale
☒ Heart Failure		☒ ECG
O - Optimise Therapy & Vaccinations	Inhaler Technique	<input type="text"/>
	Inhaler Compliance	<input type="text"/>
	Medication	<input type="text"/>
	Uses a spacer	☐
	Advice on influenza vaccine	☐
	Advice on pneumococcal vaccine	☐
	Under care of respiratory physician	☐
	Referral to respiratory service	☐
P - Pulmonary Rehabilitation	MRC	<input type="text"/>
	Pulmonary Rehab	<input type="text"/>
E - Exacerbation History	No. of COPD exacerbations per year	<input type="text"/>
	No. of COPD admissions per year	<input type="text"/>
S - Self Management	Lifestyle advice - diet and exercise	☐
	COPD self-management plan review	☐
	COPD Rescue Pack	<input type="text"/>
	Discussion about red flag signs of lung cancer	☐
Plus	Referral to social prescribing service	☐

Smoking ☒ **Vitals** ☒ **RADF**

BP mmHg

HR b...

Pulse

RR b...

Oxygen sat... %

Height 1.64 m

Weight 60 Kg

BMI K...

Eosinophils 1...

QRISK2/3 ☒ **CVD Prevent...** ☒

Inhaler Devic... ☒ **Drug Review** ☒

Immunisations ☒

Consider referral if >2 exacerbations/year despite smoking cessation, pulmonary rehabilitation and triple therapy

MRC ☒ *Score ≥3, refer for pulm rehab*

PR Referral ☒

If >2 exacerbations/year, for sputum sample + further Ix

Sputum Sam... ☒ **Radiology** ☒

myCOPD App

Do not routinely add to repeat prescription

Lung Cancer ☒

For assessment of wider determinants of health e.g. housing, fuel poverty, finances, social isolation & support

BONE HEALTH

- If receiving maintenance prednisolone 5 mg once a day or more for 3 months (or equivalent*), consider a DEXA scan and treat as per guidelines from the national osteoporosis guideline group.
- If a history of vertebral or other major osteoporotic fracture, consider treatment, as per guidelines from the national osteoporosis guideline group



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