Summary of COPD Management

QUALITY IN PRACTICE COMMITTEE

A Quick Reference Guide for Primary Care Staff

Consider Diagnosis

In any patient with dyspnoea, chronic cough or sputum production, and/or a history of exposure to risk factors for the disease.

Assess and Monitor Disease

- History
- Functional Assessment
- Physical Examination
- Spirometry is essential for accurate diagnosis**.**

Every patient with COPD should have spirometry carried out at least once by a trained person.

Checklist for assessment: (at diagnosis and follow up visits)

- Risk factors especially smoking history
- Symptoms and pattern of development
- Past medical history
- Family history of COPD
- Comorbidities
- History of exacerbations or previous hospitalisations for respiratory disease
- Appropriateness of current medical therapies
- Inhaler technique
- Impact of disease on patient's life
- Social and family support

Reduce Risk Factors

All smokers—including those who may be at risk for COPD as well as those who already have the disease—should be offered the most intensive **smoking cessation** intervention feasible.

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Management of Stable COPD

Recommended therapy according to stage of COPD:

(see Table 2 in main document for explanation of stages)

I: Mild	II: Moderate	III: Severe	IV: Very severe
Active reduction of risk factors; relevant immunisation Add short-acting bronchodilator when needed (e.g. salbutamol)			
	Add regular treatment with one or more long-acting bronchodilators of different classes (e.g. salmeterol, tiotropium); add *rehabilitation		
		Add inhaled glucocorticosteroids if repeated exacerbations (e.g. beclomethasone or combination salmeterol/fluticasone)	
			Add long term oxygen therapy (LTOT)[Ψ] if chronic respiratory failure; consider surgical treatments

* Ideally **pulmonary rehabilitation should be offered at the time of diagnosis**, which should be as early as possible in disease severity.

[Ψ] LTOT should ideally be administered continuously (i.e. 24hrs/day), as improvement in survival is only seen above a minimum usage of 15hours/day

Management of Exacerbations

Checklist for diagnostic evaluation:

- Severity class if known from when stable
- Duration/worsening of symptoms
- Number of previous exacerbations
- History to identify one of three cardinal symptoms
  - **increased breathlessness**
  - **increased sputum volume**
  - **increased sputum purulence**
- Physical examination to identify principal respiratory/cardiovascular/general signs
- Additional diagnostic procedures, e.g. chest x-ray, sputum, ECG

Factors to consider when deciding where to manage:

- Ability to cope at home
- Level of consciousness
- Already receiving LTOT
- Rapid rate of onset

Any hospital admitting acute medical emergencies should have access to non invasive ventilation (NIV).

ABC of pharmacological therapy

- Antibiotics: Oral antibiotics if sputum is purulent
- Bronchodilators: Increase frequency of bronchodilator therapy; consider nebulised therapy
- Corticosteroids: Prednisolone 30-40 mg daily for 7-10 days (no need to taper dose)

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