THE NORTH THORESBY PRACTICE

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Annual COPD Guidelines

Aim: To ensure that all patients with a diagnosis of COPD have a minimum, the offer of an annual COPD review

Policy: All patients with COPD will have a COPD recall code attached to their record, System one searches will be performed to identify all those patients who are due their COPD review, they will then be invited to make an appointment at the surgery with the GP or nurse.

In all people with COPD, at review:

- Assess adequacy of symptom control and impact of COPD on life including:
- Severity of symptoms (using the Medical Research Council [MRC] dyspnoea scale).
- Quality of life CAT score
- Exacerbation frequency and severity (including hospitalizations and treatment required).
- Consider the possibility of alternative causes for symptoms (for example asthma, bronchiectasis or lung cancer) — arrange further management as appropriate.
- Review current medications — check inhaler technique, adherence and adverse effects.
- Self-management plan and rescue medication
- Record smoking status and body mass index — offer smoking cessation support where appropriate and consider the need for nutritional support.

- Ensure that all people with COPD have been offered an annual influenza vaccination and a once-only pneumococcal vaccination.
- Assess for complications (such as cor pulmonale) or comorbidities (such as obstructive sleep apnoea, lung cancer, cardiovascular disease, osteoporosis, anxiety and depression).
- Carry out spirometry — to identify decline in FEV1 and forced vital capacity (FVC).
- Record absolute and percent predicted values.
    - A loss of 500 ml or more over 5 years indicates rapidly progressing disease — consider the need for specialist referral and investigation.
- Consider the need for further investigations, referral to a respiratory specialist, for pulmonary rehabilitation, or for social services and occupational therapy input.

In people with very severe COPD, also assess the following at review:

- Oxygen saturation using pulse oximetry — considers the need for referral to a respiratory specialist for assessment for oxygen therapy.

Adjust treatment based on symptoms and exacerbations.

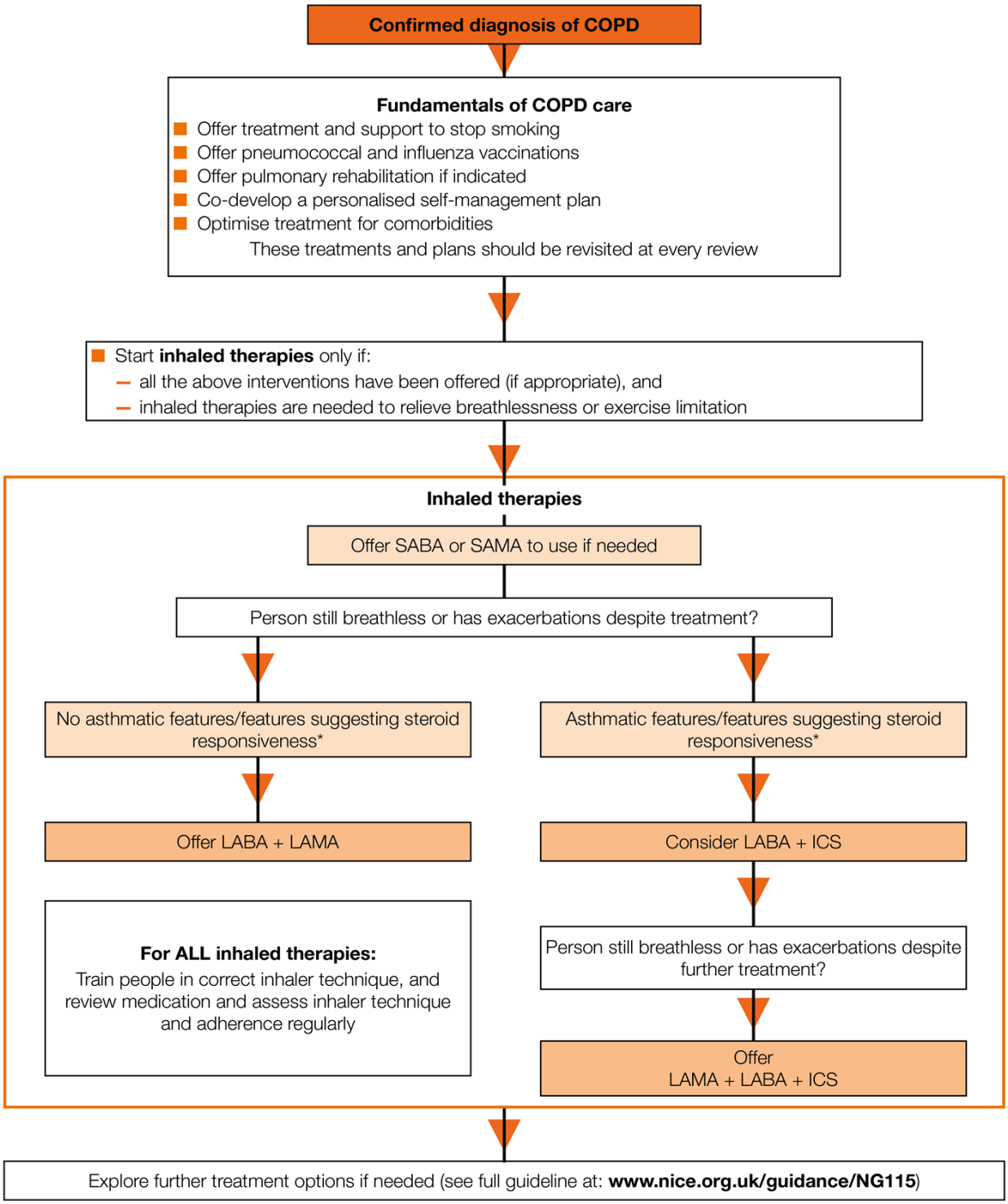
- Consider the need for referral to secondary care for consideration of additional therapies (such as roflumilast or long-term antibiotics).

NICE guidelines used for this Protocol, to be reviewed annually and checked by senior partner

Lyndsey Evans 17/05/21

https://cks.nice.org.uk/topics/chronic-obstructive-pulmonary-disease/management/stable-copd/

This is a summary of the recommendations on non-pharmacological management of chronic obstructive pulmonary disease and use of inhaled therapies in people over 16. The guideline also covers diagnosis and other areas of management (see www.nice.org.uk/guidance/NG115)



COPD=chronic obstructive pulmonary disease; SABA=short-acting beta$_2$ agonists; SAMA=short-acting muscarinic antagonists, LABA=long-acting beta$_2$ agonists, LAMA= long-acting muscarinic antagonists, ICS= inhaled corticosteroids; FEV_1=forced expiratory volume in the first second.

*Asthmatic features/features suggesting steroid responsiveness in this context include any previous secure diagnosis of asthma or atopy, a higher blood eosinophil count, substantial variation in FEV_1 over time (at least 400 ml) or substantial diurnal variation in peak expiratory flow (at least 20%).