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Guest blog - Managing COPD with Dr Azhar Saleem

Dr Azhar Saleem is a sessional GP with an interest in respiratory medicine. He is co-lead of RightBreathe, an inhaler prescribing tool for clinicians and patients. He is currently the GP Respiratory Lead at Lambeth CCG and member of the Lambeth and Southwark Integrated Respiratory Team spanning the Guys, St Thomas and King College hospital trusts.

In the UK, one in five people have a lung disease and it is one of the three biggest killers in the UK (along with heart disease and non-respiratory cancers). Mortality from lung disease stands at 115,000 per year, largely unchanged for a decade. In comparison, the number of deaths from heart disease fell by 15% from 2008 to 2012. Lung cancer and COPD account for the majority of respiratory deaths in the UK and the latter uses significant amounts of resource through emergency hospital admission and prescribing. As much as 10% of the UK population suffer with chronic breathlessness, many of them have COPD. Some will be undiagnosed COPD sufferers and the importance of diagnosing the condition early cannot be underestimated.

In the UK, the prevalence of smoking in COPD patients is around 40%, which is unacceptably high and double the prevalence of the rest of the population. Several reasons are likely to be the cause of this and as health care professionals it is our role to reduce this and improve the lives of our patients.

Early diagnosis of COPD is an important tool, but diagnostic difficulty is one of the biggest challenges in COPD. Around 30% of COPD patients will have their initial diagnosis in hospital after suffering an acute exacerbation. This usually means lost opportunities as COPD is a disease of insidious onset.

The quality of spirometry in primary care is also an area of significant variance. Levy et al 2009, found that much spirometry in primary care does not meet the quality assured standards according to the Association of Respiratory Technology and Physiology (ARTP). Furthermore, around 2/3 of GP interpretation of spirometry results did not agree with an expert panel. Quality assured spirometry carried out in community hubs by ARTP accredited health care professionals is what we need to aspire to.

Once we have diagnosed a patient correctly, robust smoking cessation services are needed to help smokers quite but unfortunately local authority budget cuts mean some of the most important specialist interventions are at risk. We need to find smarter ways to work within larger populations to ensure specialist smoking cessation services survive and can integrate with healthcare provision to reach those that need it. The London Clinical Senate have provided an excellent guide of how to approach tobacco dependence here.

When treating patients for nicotine dependence, one of the major take home messages is that we don’t prescribe enough nicotine replacement therapy (NRT). The evidence also now points quite firmly to safety with all NRT and current cessation treatments including Varenicline. The latter was used with extra caution in patients with any history of mental illness but the black box warning no longer applies and the caution is no longer required.

We need to get more of our COPD patients attending pulmonary rehabilitation (PR) and to do that effectively, we need to be well versed in describing what PR is and why it is beneficial. PR has level one evidence proving its impact on several measures of function in COPD patients. Explained as being like a gym or exercise class can put patients off, a great guide can be found at the BLF’s website here.

The final step in COPD care is prescribing and of the top five costliest treatments to the NHS, three are inhalers. Primary care prescribing budgets in COPD are similar to the whole secondary care budgets for all COPD care. Inhaler prescribing is complex and often not understood well, there are 91 inhalers to choose from in the UK. There are many different devices and prescribers often don’t know the intricate details of these devices and even struggle to train patients on them. As a result, some patients have been on doses as high as 2000mcg of beclometasone equivalent due to inappropriate prescribing against guidelines.

The costs of inhalers at these high doses are astronomical with a side effect profile similar to doses of oral prednisolone. A study in the journal Chest has recently shown that in 40 years, errors with inhaler use are still unacceptably high. Various studies have now shown that it is safe to withdraw COPD patients from these high doses so that they are either on low doses of ICS or they are withdrawn from them completely. To aid respiratory prescribing and inhaler technique training, the RightBreathe website and patient app is an innovative new electronic resource that will be released in Jan 2017. The website helps clinicians prescribe appropriately for the stage of disease in COPD. The app helps patients to set themselves dose reminders and access inhaler technique video content for any inhaler, further details can be found here.

Note: some footnote references in this article have been replaced by hyperlinks to the source material where available. Please contact Londonwide LMCs if you would like the full list of footnotes.