

Asthma focus

This briefing focuses on inhaled treatments for asthma and provides advice and guidance on improving care in asthma patients. The [bulletin and support materials](#) will help practices identify and review at risk patients as well as ensure appropriate patients are stepped down on the treatment pathway.

Key recommendations

- Ensure that when a patient is first prescribed an inhaler they are shown how to use it and that they can demonstrate they are able to use it, and that inhaler technique is assessed on a regular basis (the inhaler technique assessment support tools can be used by healthcare professionals to support inhaler technique assessment and provide written information to the patient on improving inhaler technique).
- If more than one inhaler is prescribed, regimens should be kept simple so patients do not have to learn to use many different types of inhaler, e.g. if a patient has a pressurised metered dose inhaler (pMDI) reliever inhaler and are able to use it (with or without a spacer) then prescribe a pMDI if they need an inhaled corticosteroid (ICS) or ICS/long acting beta agonist (LABA) inhaler.
- Ensure management of asthma is in line with the British Thoracic Society/Scottish Intercollegiate Guidelines Network (BTS/SIGN) guidelines and that patients are regularly reviewed. The supporting treatment pathway documents can be adapted to add local formulary choices.
- Identify and review all patients at high risk of exacerbations and death to ensure their management is improved. Searches and an audit are available to help identify these patients.
- Ensure patients on high doses of ICS are regularly reviewed and stepping down of treatment is attempted at regular intervals (every three months). Searches and an audit are available to support this review.

High dose inhaled corticosteroids

The adverse event profile of high dose ICS used over a prolonged period are well known. They include adrenal suppression, reduced bone mineral density pre-disposing patients to osteoporosis, diabetes, glaucoma, cataracts, hoarseness, dysphonia, psychological and behavioural effects and candidiasis of the mouth or throat. It is therefore sensible to ensure that the dose of an ICS is no higher than necessary to keep a patient's asthma under good control.^{3,4}

The London Respiratory Network have developed a [high dose ICS safety card for adults](#), which should be given to any patients aged 12 years and over taking high doses of ICS.

Supporting evidence

The [National Review of Asthma Deaths](#) (NRAD) report was published in May 2014.¹ The key recommendations relating to medicines were:

- Patients using more than 12 SABA inhalers in the past 12 months should be invited for an urgent asthma review.
- An assessment of inhaler technique should be routinely undertaken and formally documented at annual review, and also checked by the pharmacist when a new device is dispensed.
- Non-adherence to preventer ICS is associated with increased risk of poor asthma control and should be continually monitored.
- The use of combination inhalers should be encouraged. Where LABA bronchodilators are prescribed for people with asthma, they should be prescribed with an ICS in a single combination inhaler.

BTS/SIGN² guidelines on asthma recommend a stepwise approach to asthma treatment. Quite often patients are stepped up but then not regularly reviewed and stepped down the treatment pathway. Before starting a new drug or stepping up treatment, the patients understanding of the role of treatment, adherence to treatment, inhaler technique, and appropriate elimination of trigger factors should be confirmed. Control of asthma should be assessed after an agreed duration, depending on the desired outcome.

Costs

Focus should be on reviewing patients on ICS and LABAs and stepping down their treatment (where appropriate) to lower dose ICS/LABA or ICS alone, rather than solely focusing on switching to a cheaper combination inhaler. Better management with regular clinical review and stepping down as appropriate may provide greater cost-savings and better quality care. Where more than one product is suitable and acceptable to the individual, then the least costly should be chosen.

Options for treatment review and switching include (see [data pack](#) for full set of savings and further data):

Stepping down patients from high dose ICS/LABA combination inhalers to low/moderate dose ICS/LABA inhalers could **save up to £8.9 million across England annually. This equates to £15,777 per 100,000 patients.**

DuoResp Spriomax® has been granted a licence as equivalent to Symbicort® via an EU hybrid license application. Switching Symbicort® (200/6 and 400/12 inhalers only) on a dose for dose basis **could release 20% savings (£14.6 million annually across England or £25,858 per 100,000 patients).**

References

1. Royal College of Physicians. National Review of Asthma Deaths (NRAD). Confidential enquiry report. May 2014
<http://www.rcplondon.ac.uk/projects/national-review-asthma-deaths>
2. BTS/SIGN. British Guidelines on the Management of Asthma, May 2008 (revised October 2014). <http://www.sign.ac.uk/pdf/SIGN141.pdf>
3. MHRA. Long-acting beta2 agonists: reminder for use in children and adults. Drug Safety Update September 2010; 4 (2)
<http://www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON093877> Accessed 25/06/2014
4. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press. Accessed 21/01/2015
<http://www.medicinescomplete.com>

Additional resources available



Bulletin



Data pack



Audits, letters, leaflets, searches

<http://www.prescqipp.info/resources/viewcategory/316-asthma-focus>

<http://www.prescqipp.info/projects/respiratory-care-webkit#inhaler-technique-assessment-tools>