**Asthma - Management and Prescribing - Adults**

**CONFIRM ASTHMA DIAGNOSIS**

Symptoms and signs of asthma (high or intermediate probability on BTS/SIGN guidance), including:
- Recurrent episodes of symptoms
- Symptom variability (diurnal variation)
- Absence of symptoms of alternative diagnosis
- Recorded observation of wheeze
- Personal history of atopy
- Historical record of variable PEFR or FEV1

Positive objective and subjective improvement after 6 weeks treatment with an inhaled corticosteroid.

**ASSESS FOR TREATABLE TRAITS**

Assess the patient for the following treatable traits:
- Smoking cessation
- Gastro-oesophageal reflux disease (GORD)
- Rhino-sinusitis
- Anxiety
- Obesity

**INHALED THERAPIES**

See page 2 for prescribing inhaled therapies

**MONITOR AND REVIEW**

Monitor and review response to management:
- Review after 3 months with any treatment changes
- Use objective measures of asthma control to step up AND step down inhaler therapies – see page 3
- Offer annual review appointments to all patients with asthma – consider asynchronous consultation review using eConsult
- Check adherence and inhaler technique at every opportunity

**REFERRAL TO SECONDARY CARE**

Consider referral to secondary care for the following reasons:
- Diagnostic uncertainty
- Poor or no response to specialist therapies
- ≥ 3 acute exacerbations in the past 12 months

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All guidance will routinely be reviewed every 24 months from the “last review” date. Information contained in this document is intended as guidance of best practice.
Dry Powder Inhaler Choices

- Salbutamol or Terbutaline as required to relieve wheeze or breathlessness (unless using MART).

Special prescribing notes (costs above are for 30 days supply):
- stepping up or stepping down treatment:
  - Two puffs twice daily

- Prescribe by brand to ensure correct device

- Fostair NEXThaler after first opening the pouch, the medicinal product life of devices:
  - 3 months after opening the foil pouch

- Respiratory MCN – management advice

- Consider moving up if using ≥ 3 doses per week. Try to maintain pMDI or DPI consistency.
Asthma Prescribing Guidance Explained

It is important that medications are chosen on an individual patient basis and that the most appropriate inhaler device is chosen for each patient based on their competency in using inhaler devices. A range of inhalers are recommended to offer clinicians and patients flexibility in choosing or changing treatments.

Objective Measures of Asthma Control

At all stages of treatment an objective assessment of asthma control should be undertaken to determine if inhaled therapies should be adjusted – consider using Asthma Control Test (ACT)

Markers of good control:
- ACT > 20
- < 3 SABA used in 12 months
- no exacerbations of asthma in previous 12 months

Markers of poor control:
- ACT < 20
- ≥ 3 SABA used in 12 months
- ≥ 1 acute exacerbation(s) of asthma in previous 12 months (including GMED, Emergency Department or admission)

Markers of high risk or severe asthma:
- > 12 SABA used in 12 months
- Patients on maximal inhaled therapy with
  - ACT < 20
  - ≥ 3 SABA used in 12 months
  - ≥ 2 exacerbations requiring oral steroids

Objective measures of asthma control should allow clinicians to safely step down asthma medications. To support clinicians in managing step down safely and effectively the following points should be considered and discussed with patients.

- Asthma is a variable disease from day to day and month to month and therefore the treatments required can vary too.
- Whenever a patient’s treatment is stepped up consider phrasing this as a “temporary measure” until good asthma control is achieved and inform patients that you will aim to step treatment down again when it is safe to do so
- Step down should only be undertaken when there is objective evidence of good asthma control
- Loss of asthma control after step down is not an indication that step down was an error or a failure. Approximately 1 out of every 6 patients with well controlled asthma can lose control of their asthma over a 6 month period whether they have treatment changes made or not.

Greener Respiratory Care

Inhaler therapies account for approximately 3% of the total carbon footprint of the NHS. The majority of the carbon emissions from inhaler therapies is from reliever SABA medications in a pMDI.

The MCN do not feel that the carbon footprint of different inhaler therapies should be a significant factor in deciding which medications should be included on prescribing guidance but will continue to review the available evidence and support greener respiratory care in principal. There are some simple steps that can be taken which help to reduce the carbon footprint if inhalers that the MCN would support:
- Improve asthma control – results in a reduction in the excess use of SABA pMDI devices and thus reduce CO₂ emissions
- Prescribe either a DPI SABA (if suitable) or generic pMDI - Ventolin has twice the amount of CO₂ emissions as other pMDI Salbutamol and should avoid prescribing as brand name. Ensure spacers are used with pMDI to increase effectiveness
- Consider whether SABA is required as a repeat item – this may encourage over-ordering by patients or automated ordering services
- Encourage patients to return all inhalers to community pharmacies for either recycling schemes or incineration

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