

Suffolk Chronic Obstructive Pulmonary Disease (COPD) Guidelines

Diagnosis

Medical History:

- Smoker/ex-smoker
- Exposure to risk factors - occupational exposure, air pollution
- Family history
- Co-morbidities
- Check for asthma - documented reversibility (variation in FEV1 over time, at least 400ml) / diurnal variation in PEFR, at least 20%)
- History of rhinitis
- Atopic eczema
- Nasal polyps
- Variable breathlessness
- Exacerbations
- Psychological factors
- Signs of respiratory failure or right heart failure

Testing for diagnosis:

- Spirometry quality assured. Spirometry can be done during a non-severe exacerbation if not possible during a period of stability
- Consider chest x-ray if not had in last 12 months
- Body mass index (BMI)
- FBC, U&Es, HbA1c
- Pulse oximetry (if cyanosis or cor pulmonale)
- Alpha-1 antitrypsin deficiency - if <60 years old and no smoking history request alpha-1 antitrypsin levels. Phenotype requested only if levels are low
- [Medical Research Council Dyspnoea Scale](#) (mMRC)
- [COPD Assessment Test](#) (CAT)
- Eosinophils - oral corticosteroids can impact the test so measure baseline eosinophils when the patient is well. Inhaled steroids at licensed doses for COPD don't impact eosinophil counts significantly

Criteria for specialist advice

Referral for advice, specialist investigations or treatment may be appropriate at any stage of disease

- Diagnostic uncertainty
- Suspected severe COPD
- Onset of cor pulmonale
- Dysfunctional breathing
- Bullous lung disease
- Rapid decline in FEV1
- Haemoptysis
- Frequent infections
- Assessment for lung volume reduction surgery or lung transplantation
- The individual requests a second opinion
- Assessment for oxygen therapy, long-term nebuliser therapy or oral corticosteroid therapy
- Symptoms disproportionate to lung function deficit
- Onset of symptoms under 40 years or a family history of alpha-1 antitrypsin deficiency

Fundamentals of COPD care

Offer and review at least annually

- Offer treatment and support to stop smoking - [Feel Good Suffolk/Essex Wellbeing Service](#)
- Offer pneumococcal and annual influenza vaccination
- Offer COVID and RSV vaccination if eligible
- Offer pulmonary rehabilitation. Patient can have multiple referrals. Not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

[Community services in north Essex](#) 0300 0032 112

- Co-develop a personalised self-management plan. [Action plan](#)
- Ensure correct use of inhalers and patients can demonstrate technique. [Inhaler technique videos](#)
- Optimise treatment for comorbidities
- Refer patients for dietetic advice if they have an abnormal BMI (high or low) or changing over time and encourage exercise/activity
- Provide patient with links to further education and support groups

[Chronic obstructive pulmonary disease \(COPD\) | Asthma + Lung UK](#)

[Chronic obstructive pulmonary disease \(COPD\) - NHS](#)

[Steroid Emergency cards](#)

Pharmacological Management

Diagnosis must be confirmed with spirometry, do not continue until diagnosis is confirmed.

For patients with a diagnosis of asthma and COPD, treatment with ICS is mandatory and should be titrated accordingly.

For patients currently treated for COPD using ICS/LABA, reassess the need for ICS. See [page 69 of '2026 Gold Report'](#)

Ensure patient is aware that inhaled therapies will not resolve all breathlessness

SABA – as needed to all patients for immediate symptom relief. Should be continued prn throughout all treatment

Salbutamol Easyhaler Dry Powder Inhaler (DPI) ■

Salamol Metered dose inhaler (MDI) with spacer ■

Before stepping up treatment and specialist referral check:

- Inhaler technique and adherence
- Optimise co-morbidity treatment
- Refer to pulmonary rehabilitation
- Refer to **fundamentals of COPD care**
- Consider chest X-ray if not had in previous 12 months
- Consider sputum samples if recurrent exacerbations, this should be done before starting an antibiotic

0 or 1 moderate exacerbations not leading to a hospital admission
mMRC 0-1
CAT 0-10

If SABA required daily

0 or 1 moderate exacerbations not leading to a hospital admission
mMRC ≥ 2
CAT >10.

≥2 moderate exacerbation or ≥1 leading to hospitalisation
mMRC ≥ 2
CAT >10
Check blood eosinophils

Eosinophils <0.3x10⁹

Eosinophils >0.3x10⁹

Offer LAMA+LABA

Anoro Ellipta DPI ■

Spiolto Respimat ■

Bevespi Aerosphere MDI ■ with spacer

Offer LABA+LAMA+ICS - 3-month trial

Trelegy Ellipta DPI ■

Trimbow MDI 87/5/9 extra fine particles ■ with spacer

Trimbow NEXThaler DPI 88/5/9 extra fine particles ■

Trixeo Aerosphere MDI ■ with spacer low carbon propellant

- Only use inhalers at licensed doses for COPD
- Inhaled steroids increase the risk of pneumonia; ensure they are only used where benefit outweighs risk.
- Document reason for continuing ICS after 3 month trial.

Continued/increased exacerbations
Check all points in 'Before stepping up treatment and specialist referral' box
Check Blood eosinophils

Eosinophils >0.3 x10⁹

Eosinophils <0.3 x10⁹

- If no improvement after 3-month trial or
 - Pneumonia starts after commencing LABA+LAMA+ICS **revert to LAMA+LABA**
- Check all points in 'Before stepping up treatment and specialist referral box' have been addressed.

Check all points have been addressed in 'Before stepping up and Specialist referral box' before considering Advice and Guidance (A&G) to secondary care respiratory.

Carbon footprint per puff

■ -low <35gCO₂e

■ -high >35gCO₂e

Mucolytics

- May be initiated on trial to thin mucosal secretions in respiratory tract disorders, characterised by excessive, viscous mucus, including COPD
- A trial should be considered once a diagnosis has been confirmed and the patient has stopped smoking
- Review patient after 4 weeks; stop treatment if no benefit is shown or has side effects (e.g. dyspepsia/diarrhoea)
- Continue if there is symptomatic improvement (for example reduction in frequency of cough and sputum production)
- Mucolytics should not be used routinely to prevent exacerbations in people with stable COPD

Exacerbation/Rescue Packs

- An exacerbation is a sustained worsening of the patient's symptoms from their usual stable state, which is beyond normal day-to-day variations, and is acute in onset. Commonly reported symptoms are:
 - Worsening breathlessness
 - Worsening cough
 - Increased sputum production
 - Change in sputum colour
- It is essential to exclude other acute conditions that may mimic or contribute to the presentation and are potentially life-threatening. Consider alternative or additional diagnoses such as:
 - Pneumothorax
 - Pneumonia
 - Heart failure
 - Pulmonary embolism
 - Arrhythmias
- Ensure patient is educated around rescue packs. This includes:
 - A [self-management plan](#) with clear instructions for when to take prednisolone and/or antibiotics
 - Patients should inform a health care professional (HCP) that they have started their rescue pack within 48 hours of starting it, and they should be reviewed after the taking the rescue pack medication.
 - Patients should be aware of what to do if symptoms worsen.
- Consider sputum sample if patient has mucopurulent sputum

Environmental Considerations

The NHS long-term plan proposed a 50% reduction in the greenhouse gas emissions from inhalers by 2030 through reducing use of MDIs.

- A DPI should be favoured if it is suitable for the patient. The choice should be made on an individual basis between the clinician and patient.
- We do not advocate 'blanket switching' of patients from MDIs to DPIs.
- The favoured salbutamol MDI is Salamol, due to its relatively low carbon footprint compared to other preparations.
- Patients should be encouraged to return inhalers to their pharmacy for incineration. More carbon emissions are released when inhalers, even empty ones, are disposed of in a landfill site compared to incineration. For further resources on lower carbon impact click [here](#) Chapter 3 Respiratory – Lowering Carbon Impact. Please note a log in is required and can be requested.

Key to abbreviations:

FEV1	forced expiratory volume in 1 second
PEFR	peak expiratory flow rate
GOLD	Global Initiative for Chronic Obstructive Lung Disease
DPI	dry powder inhaler
MDI	metered dose inhaler
SABA	short acting beta-2 agonist
ICS	inhaled corticosteroid
LAMA	long acting muscarinic antagonist
LABA	long acting beta-2 agonist

This guidance is applicable for Suffolk practices only-guidance was developed and produced prior to the formation of the Norfolk and Suffolk ICB in April 2026

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