NHS
Suffolk and
North East Essex
Integrated Care Board

Management of asthma in adults (18+)

Pharmacological management

- **There are 2 options for asthma treatment: The NICE AIR/MART regimen or the traditional regimen which involves separate relievers and preventers.**
- **Clinicians should initiate new patients based on the 2024 NICE AIR/MART guidance.**
- **To reduce carbon footprint dry powder inhalers (DPIs) are preferred over metered dose inhalers (MDIs)if suitable for the patient.**

	Symptoms less than 3 times a week	**Symptoms most days or waking with asthma once a week or more**	**Daily symptoms or waking with asthma once a week or more and where low dose MART is not sufficient**	**Daily symptoms or waking with asthma once a week or more where moderate dose MART is not sufficient**	**Specialist care management**
AIR (anti-inflammatory reliever) MART (maintenance and reliever therapy) regimens ICS/Formoterol	**AIR** **As required in response to symptoms** **Fostair® 100/6** NEXThaler** **Proxor® 100/6** MDI via spacer** **DuoResp Spiromax® 160/4.5** **Fobumix® 160/4.5 Easyhaler**	**Low dose MART** **1 PUFF BD+PRN** **Fostair® 100/6 NEXThaler Max 8 puffs/day** **Proxor® 100/6 MDI via spacer Max 8 puffs/day** **DuoResp Spiromax® 160/4.5 Max 8-12 puff/day and 6 puffs per episode** **Fobumix® 160/4.5 Easyhaler Max 8-12 puff/day and 6 puffs per episode**	**Moderate Dose MART** **2 PUFFS BD+PRN** **Fostair® 100/6 MD NEXThaler Max 8 puffs/day** **Proxor® 100/6 MDI via spacer Max 8 puffs/day** **DuoResp Spiromax ® 160/4.5 Max 8-12 puff/day and 6 puffs per episode** **Fobumix® 160/4.5 Easyhaler Max 8-12 puff/day and 6 puffs per episode** ***▲Provide steroid emergency card*** here	**Check Blood eosinophil count + FeNO if access** **If within normal limits** Consider adding **Montelukast 10mg ON** +/- **Spiriva Respimat® 2 puffs daily** If **either** are raised **refer to specialist care**	
Traditional Asthma regimen DPI	**No adult asthma patient should be on a blue reliever inhaler alone (NICE 2024)** **Salbutamol Easyhaler® 100mcg** 1-2 puffs prn (up to qds)	**Beclometasone Easyhaler® 200mcg** 1 puff bd **Budesonide Easyhaler® 100mcg** 1 puff bd	**Fostair® 100/6 NEXThaler** 1 puff bd **DuoResp Spiromax® 160/4.5** 1-2 puffs bd **Fobumix® 160/4.5 Easyhaler** 1-2 puffs bd	**Fostair® 100/6 NEXThaler** 2 puffs bd **DuoResp Spiromax® 160/4.5** 4 puffs bd **Fobumix® 160/4.5 Easyhaler** 4 puffs bd	**Seek Specialist advice before initiating** **Fostair® 200/6 NEXThaler** 2 puffs bd **Fobumix® 320/9 Easyhaler** 1-2 puffs bd **DuoResp Spiromax® 320/9** 1-2 puffs bd
MDI	**Salamol® 100mcg MDI** 1-2 puffs prn (up to qds)	**Clenil Modulite® 100mcg MDI** 1-2 puffs bd	**Proxor® 100/6 MDI** 1 puff bd	**Proxor® 100/6 MDI** 2 puffs bd	**Proxor® 200/6 MDI** 2 puffs bd

****Please note Fostair are Proxor are not currently licensed for AIR however it is considered there is a class effect (ICS/Formoterol). All inhalers are licensed for MART.****

In AIR/MART regimen, all inhalers are DPIs except Proxor MDI (metered dose inhaler)

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Diagnosis

- Consider typical symptoms – wheeze, sob, cough, esp. at night, triggers, atopy and variability
- Document audible wheeze on auscultation
- Consider triggers including occupation and smoking history
- If clinical picture is suggestive, consider the need for confirmation of evidence including:
  - Eosinophil count is ≥ 0.4
  - Elevated FeNO measurement (≥ 50ppb suggests eosinophilic airway inflammation)
  - Spirometry with reversibility (though spirometry is commonly normal). Diagnose asthma if reversibility is greater than 12% from baseline or greater than 200 ml (or > 10% of predicted normal).
  - Serial PEF (esp. >20% diurnal variability, though generally only present in 30% of asthmatics)
- Assess asthma control using ACT Asthma Control Test
- Consider comorbidities contributing to symptoms (rhinitis, COPD, bronchiectasis, GORD, obesity, OSA)

Seek specialist advice or referral if:

- Diagnostic uncertainty or unexpected symptoms/signs (eg restrictive spirometry, crackles, abnormal CXR, clubbing, crackles, stridor, persistent sputum, recurrent bacterial sputum culture)
- Admission to hospital for poorly controlled asthma
- Asthma remains uncontrolled after 3 months following treatment optimisation esp. recurrent exacerbations (≥2 prednisolone courses per year)
- Suspected occupational asthma
- Poorly controlled asthma in pregnancy
- Consideration of treatment with long term antibiotics
- Consideration of biologic therapy (anti IgE or anti eosinophil)
- If there are possible complicating lung conditions (e.g. vasculitis, allergic bronchopulmonary aspergillosis or bronchiectasis)

Stepping UP – Think TTT first, then move up to improve control if needed Before initiating a new drug therapy or stepping up, practitioners should check:

• Concordance with existing Therapy
• Inhaler Technique
• Trigger factors

If not getting expected response, confirm diagnosis. Seek advice in preference to continually escalating treatment. After stepping up, it is recommended to review patient in 8 weeks

Stepping DOWN – Move down to find and maintain lowest controlling therapy

• Complete control needs to be maintained for 12 weeks before stepping down
• After stepping down, review in 12 weeks: step patient up again if symptomatic during this period
• Stepping down before 12 weeks of control can lead to exacerbations and hospital admissions

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 information on lower carbon impact see further resources here

Spacer devices

• A spacer device must be given to all patients using an MDI
• Prescribe a spacer device that is compatible with the MDI
• They should be cleaned monthly by taking it apart and washing in a mild detergent, before leaving to air-dry, the mouthpiece should be wiped clean before using
• They should be replaced every 12 months
• Spacers are not widely recyclable so should be disposed of in the normal household waste

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Asthma reviews

- All patients should receive education about their condition ideally at diagnosis
- Assess risk of exacerbations – factors to consider:
  - Previous exacerbations
  - Overuse of B2 agonists (3 or more inhalers per year)
  - Adherence to preventers
  - Comorbidities: rhinitis, BMI, psychiatric illness
  - Impaired lung function
  - Evidence for uncontrolled inflammation (raised FeNO, and blood eosinophils)
- Every patient needs a Personalised Asthma Action Plan (PAAP) - found here
- Assess symptom control ACT Asthma Control Test
- Review exacerbation rate, prednisolone courses, admissions and time off work/school
- Review SABA reliance (consider AIR or MART)
- Check PEF
- Inhalers
  - Check technique - how inhaler technique video here
  - Prescribe by brand to ensure device continuation.
  - Review the environmental impact, favouring DPIs and avoiding Ventolin MDI
  - Ensure device consistency across therapy to enhance adherence
- Consider stepping asthma therapy **down** after at least 12 weeks of good asthma control.
- If asthma control is poor:
  - Recheck diagnosis
  - Check adherence with therapy, inhaler technique and smoking status
  - Review asthma triggers especially environmental factors, damp and mould, occupation
  - Check FeNO, eosinophil count (if high check IgE consider secondary care referral)
  - Consider comorbidities:
    - Rhinitis
    - BMI and Obstructive Sleep apnoea
    - GORD
    - Bronchiectasis/ bacterial infection
    - Dysfunctional pattern of breathing
- Always offer smoking cessation advice/support and weight loss support. Feel Good Suffolk access here and Essex Wellbeing Service access here
- Encourage flu vaccination
- All asthmatics discharged from hospital post exacerbation should be seen by a GP/practice asthma nurse within 4 weeks

Converting from traditional asthma regimen to AIR/MART regimen

If patients are not symptomatic and are happy on their current treatment pathway it is not recommended that they are switched unless they are on SABA monotherapy which must be switched.

Please see here for inhaled corticosteroids doses

