NHS
Northern Lincolnshire
Area Prescribing Committee

Stepwise Management of Asthma in Adult Patients

Step 1

Inhaled short-acting β2 agonist (SABA) as required.

- Salbutamol 100 micrograms CFC Free MDI (Ventolin Evohaler)
- Salbutamol 100 micrograms Breath Actuated CFC Free MDI (Salamol Easi-Breathe)
- Salbutamol 100 micrograms DPI (Easyhaler)

Step 2

Add inhaled steroid 200-800 micrograms/day. Usual adult starting dose is 400 micrograms (200 micrograms BD). However, the lowest steroid dose to achieve control is required.

- Beclometasone 100-400 micrograms MDI (Clenil Modulite)
- Beclometasone 50-100 micrograms Breath Actuated MDI (Qvar Easi-Breathe)
- Beclometasone 100-400 micrograms DPI (Easyhaler)

Step 3

Add inhaled long-acting β2 agonist (LABA) to inhaled steroid as a combination product.

Assess control of asthma:

- Good response to LABA = continue LABA
- Benefit from LABA but control still inadequate = continue LABA and increase inhaled steroid dose to 800 micrograms/day (if not already on this dose)
- No response to LABA = stop LABA and increase inhaled steroid to 800 micrograms/day.

- Beclometasone 100 micrograms and Formoterol 6 micrograms CFC Free MDI (Fostair)
- Fluticasone and Formoterol MDI (Flutiform)
- Fluticasone and Salmeterol MDI (Seretide Evohaler 125 or 250 - NB 250 is a HIGH asthma dose)
- Fluticasone and Salmeterol DPI (Seretide Accuhaler 100 or 250)

Step 4

Initiate trial of leukotriene receptor antagonists or long acting β2 agonist tablet and/or consider trial periods of increasing inhaled steroid up to 2000 mcg/day (short durations only).

- Fluticasone and Salmeterol DPI (Seretide Accuhaler 250 or 500)
- Budesonide and Formoterol DPI (Symbicort Turbohaler 200/6 or 400/12)
- Montelukast 10mg Tablet (Singulair)
- Salbutamol 4mg or 8mg Tablets (Ventmax SR)

Step 5

Use daily steroid tablet in lowest dose providing adequate control. Maintain high dose inhaled steroid at 2000 mcg/day. Consider other treatments to minimise the use of steroid tablets. Refer patient for specialist care.

- Prednisolone Tablets 5mg
- Hydrocortisone Tablets 10mg or 20mg

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Consider Step 1 through to Step 5 in sequence. Always start at the lowest appropriate step. Once the patient is moved to the next step, schedule a review within 6 months to ascertain control and consider stepping reverting to the previous step as appropriate providing control as defined below is achieved. The starting dose of inhaled steroid should be tailored to the severity of the condition. The emphasis must be on prescribing the lowest dose of therapy to maintain control. This will reduce side effects, increase patient compliance and lead to a reduced financial impact. Maintain the same type of device e.g. DPI or MDI, throughout therapy where possible.

The aim of asthma management is control of the disease. Complete control is defined as:

- No daytime symptoms
- No night time awakening due to asthma
- No need for rescue medication
- No exacerbations
- No limitations on activity including exercise
- Normal lung function (in practical terms FEV1 and/or PEF >80% predicted or best)
- Minimal side effects from medication

Always check inhaler technique. A recent study conducted in the Isle of Wight suggested that up to 80% of acute hospital admissions were due to poor medicine use, including poor inhaler technique, rather than incorrect prescribing. Where possible, if patients are on more than one inhaler, keep to the same type of device. The inhalation rate differs greatly between devices.

The MHRA states that all CFC free MDIs containing beclometasone should be prescribed by brand where appropriate. For this guideline, the same applies to all steroid inhalers.

The British Thoracic Society (BTS) Guidelines suggest no increased clinical efficacy with combination inhalers, but there is evidence of greater compliance and control. Therefore, combination products such as Fostair and Seretide should be prescribed rather than single medicine inhalers, unless there is a specific reason otherwise.

Always refer to the BTS guidelines, SPC and BNF guidance when making a clinical decision. This document is a guideline and professional judgement should always prevail. This guideline applies to patients aged 18 years and above.

The brand names suggested in the above pathway have been assessed as providing quality patient outcomes whilst optimising medicine prescribing. Other appropriate devices may exist. Company names, brand names, logos and trademarks used in this guidance document remain the property of their respective owners.

Reference:

British Thoracic Society (2008, Revised 2012). *British Guideline on the Management of Asthma. A national clinical guideline*. 5th ed. Edinburgh and London: Scottish Intercollegiate Guidelines Network & British Thoracic Society. p37-56.