**March 2022 Respiratory Newsletter**

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**Dear Colleagues**

It is time for another round up on the latest news from the world of respiratory health. Keep up the good work and look after your own health and support your colleagues as the last two years has been hard for everyone. Look at the Life work balance cycle and remember that a healthy planet promotes health for all of us. Do a NHS MIND plan quiz and get your personalised emotional well-being plan. <https://www.nhs.uk/every-mind-matters/mental-wellbeing-tips/your-mind-plan-quiz/>

This time we are focussing again on asthma and reflect on what the latest GINA/WHO 2021 asthma guidance tells us. This is the approach we are now following across Kent/Medway.

**Lessons from GINA 2021 Asthma Update:**

Back in 2019 a major change in approach to asthma management was put forward by UK and global asthma experts showing a complete break from the traditional Salbutamol/SABA as needed approach in asthma. It had become clear for some time that those patients on SABA became over-reliant on salbutamol and would rarely use the inhaled corticosteroids/ ICS inhalers. Setting patients off on the wrong foot at time of diagnosis has meant we have been unable to break the cycle of high SABA & low ICS use; leading to unstable poorly controlled asthma with its hazards of life threatening attacks and even deaths. Dr Mark Levi et al. NRAD UK 2015.

The evidence is quite clear Salbutamol mono-therapy makes our lung airways more unstable, more reactive to allergens, and is linked to increased risk of severe asthma attacks and admissions. So what is the best way forward?

GINA has suggested that from day ONE all asthma patients no matter how mild or sporadic should be on inhaled steroids/ICS. The salbutamol only approach has no place in modern management of asthma even for the mildest asthmatic patients. The asthma inhaler treatment strategies suggested:

1. Combination LABA/ICS inhalers is the best option and are should be given from day one – the formoterol + inhaled steroid using either Symbicort 100 or Fostair fixed dose is step one/two from age 12 years. It can be flexi-dose SMART/MART option at step three. Flexible dose regimes with ICS/LABA is always a good choice for older children from age 12 years when parental monitoring is less robust! Note: *Symbicort 100* has a license from age six at a fixed dose.
2. When using SMART/MART approach do NOT co-prescribe salbutamolas this will not reduce over-reliance on salbutamol. Best to tell patients that the 2 in 1 inhalers have a“salbutamol plus”effect and give best protection against asthma attacks.
3. If salbutamol is being prescribed you must also co-prescribe an inhaled steroid like Clenil for under 12’s or QVAR for over 12’s. With the proviso being they must use BOTH ICS and salbutamol together whenever they are symptomatic – like in mild episodic or seasonal asthma. If needing inhalers twice a week or more they need to be on daily ICS. *Remind patients that salbutamol on its own does not protect the lungs from asthma attacks and can actually make asthma worse if inhaled steroids are not used.*
4. *Seretide 50* has a license from age 4 years but this is fixed dose regime and NOT suitable for SMART. However saying that in an asthma flare-up one can increase any ICS/LABA inhaler dose by 3-4 times – important to note that just doubling the dose is ineffective in many studies now and no longer recommended.
5. It is also important that some patients will not respond to higher dose ICS/LABA during flare-ups and should know this to access nurse/doctor advice and get a course of oral steroids. Course duration may be 3-7 days and prolonged courses are not recommended without careful re-examination/review. End point should be based on symptomatic improvement or a peak flow back to over 75% of normal. Offer follow-up when oral steroid course ends and ICS/LABA inhalers alone still seems ineffective.

**Dry powder inhalers** that work with lower inspiratory rates include the *seretide accuhaler* range; *relvar ellipta* and the breath activated *duoresp spiramax*. Turbohalers need stronger inspiration but can be managed by most patients. Note the key NICE advice – a firm deep breath in for 3-4 seconds is needed for good lung deposition in DPIs; followed by a 4-5 second breath hold. The commonest error is patients stop breathing in after the first second and most of the dry powder goes on the throat leading to coughing and oral thrush. Also the airflow problem in asthma is not during breathing in; it is slow airflow when breathing out, hence the expiratory wheeze!

*Sabutamol easyhaler* and *bricanyl turbohaler* are low carbon SABA options for the patients who are not on a SMART/MART inhaler regime. For example if you are on a fixed dose combination like seretide or relvar ellipta, you will still need a SABA inhaler as this is not a SMART/MART approach.

Signpost your patients on ICS/LABA suitable for SMART/MART the asthma UK guide:

**NICE inhaler decision tool:** this helps in choosing the right inhaler based on inspiratory flow rates. Studies show that a most patients are using their inhalers incorrectly. pMDIs require a slow and gentle inhalation whereas DPIs require a stronger and faster inhalation. Using the inhaler correctly with matching technique to the correct inhaler is important to allow maximum lung deposition.

Reducing our impact on the environment is possible and is part of the NHS zero carbon targets. Because current HFA aerosol powered MDI inhalers have potent global warming effects, the NHS and NICE suggest using where clinically appropriate HFA-free inhalers that are already available, like dry Powder Inhalers [DPi’s] and recyclable soft-mist inhalers. Switching to inhalers with lower global warming potential (GWP) by 2022 is a key part of the NHS Sustainable Development strategy.

**Covid 19 and Asthma**

Have there been more asthma exacerbations during the pandemic? § No. In 2020-21, many countries saw a reduction in asthma exacerbations and influenza-related illness. The reasons are not precisely known, but may be due to handwashing, face masks and social/physical distancing that reduced the incidence of other respiratory infections, including influenza and RSV infections.

Are people with asthma at increased risk of COVID-19-related death? § Overall, people with well-controlled asthma are not at increased risk of COVID-19-related death (Williamson, Nature 2020; Liu et al JACI IP 2021) § However, the risk of COVID-19 death was increased in people who had recently needed oral corticosteroids (OCS) for their asthma (Williamson, Nature 2020) and in hospitalized patients with severe asthma (Bloom, Lancet Respir Med 2021).

What are the implications for asthma management? § It is important to continue good asthma management (as described in the GINA report), with strategies to maintain good symptom control, reduce the risk of severe exacerbations and minimise the need for Oral Corticosteroids.

**Appendix and Useful links**

You may also find the following links helpful for further advice and guidance on COPD best practice management; plus antibiotic prescribing in community acquired pneumonia and COPD;

1. **Mental Health Staff and Teams support:** [NHS England » Wellbeing support options](https://www.england.nhs.uk/supporting-our-nhs-people/wellbeing-support-options/)
2. **GINA 2021:** [Pocket Guide for Asthma Management and Prevention - Global Initiative for Asthma - GINA (ginasthma.org)](https://ginasthma.org/pocket-guide-for-asthma-management-and-prevention/)
3. **Reducing global warming gases from inhalers:** <https://www.nice.org.uk/news/article/nice-encourages-use-of-greener-asthma-inhalers>
4. **NICE inhaler decision tool**: <https://www.nice.org.uk/guidance/ng80/resources>
5. **Asthma UK all about MART:** <https://www.asthma.org.uk/advice/inhalers-medicines-treatments/inhalers-and-spacers/mart/>

**GINA asthma guidelines: Management Charts**





