

# Guidelines for the Management of Adults with Confirmed Asthma (18 years and over)

Based on a combination of the [NICE 2021 Asthma, Guidance BTS / SIGN British Guideline on the Management of Asthma](#) July 2019 and [GINA guidance](#) April 2021

(Diagnosis is not covered by this guidance)



Consider carbon footprint of inhaler choice – where clinically possible consider use of DPI in preference to MDI. Prescribe ALL inhalers by BRAND. Click [here](#) for formulary product choices. See [NICE Patient Decision Aid – Inhalers for Asthma](#).  
If a DPI is not suitable, a pMDI +spacer is more effective and preferred to pMDI alone and as effective as DPI

Start treatment at level most appropriate to initial severity. Assess control e.g. [ACT](#) or [Ardens](#). Step up to improve control (after checking **TTT**; therapy compliance/adherence, inhaler **technique**, **trigger** factors) as needed AND Step down to find and maintain lowest controlling therapy. Follow link to [HWE ICB Step Down guidance](#). If patient is stable, consider reducing ICS dose by 25-50% every 3 months. Review every 6-8 weeks. Stepping down should be explained to patient and be part of PAAP.

## CONSIDER DPI

### Step 1: Regular Preventer

Low dose ICS with SABA for symptom relief:

**DPI:** Salbutamol Easyhaler **OR**  
**pMDI:** Salbutamol (e.g. Salamol) Inhaler

Diagnosis must be confirmed with objective tests before treatment escalation if appropriate i.e. if there is another differential diagnosis to consider

## CONSIDER DPI

### Step 2: Initial add-on therapy

(1) If asthma is still uncontrolled and an **allergic component**<sup>1</sup> is present add LTRA (**montelukast**) to low dose ICS. Review in 4-8 weeks.

Review LTRA (**montelukast**) treatment as follows:

- discuss with patient whether or not to continue LTRA (**montelukast**) treatment. If no improvement seen stop treatment and switch to LABA+ICS.  
*(montelukast is low carbon option)*

(2) Offer a LABA with ICS for **non- allergic associated asthma** (combination inhalers preferred), or if trial with LTRA was not successful.

## CONSIDER DPI

### Step 3: Additional controller therapies

(a) If benefit from LABA but control still inadequate increase to medium dose ICS/LABA (**provide steroid card**)  
(b) If no response to LABA, stop and increase to medium dose ICS  
(c) If benefit from LABA but control still inadequate continue LABA and ICS and consider trial of add-on therapy **LTRA (montelukast)**, LAMA, **SR Theophylline (Specialist initiation ONLY, annual monitoring required)**

**CONSIDER REFERRAL TO COMMUNITY RESPIRATORY SERVICE (HVCCG)/SECONDARY CARE (ENHCCG) FOR SPECIALIST INPUT IF ASTHMA REMAINS UNCONTROLLED**

## CONSIDER DPI

**REFERRAL TO COMMUNITY RESPIRATORY SERVICE (HVCCG)/SECONDARY CARE (ENHCCG) FOR SPECIALIST INPUT**

**Step 4: Consider trial of increasing ICS high dose**

**OR**  
**Add LAMA**

**OR**  
**LTRA (montelukast)**

**HOSPITAL ONLY INITIATION:**  
**SR theophylline**  
**beta2 agonist**  
**Biologic therapy if criteria is met (RED listed)**

Consider MART Therapy [Click here for licensed regimes](#) Appropriate for patients on **Step 2 or 3** with a PAAP, able to self-manage, compliant with their own treatment. ([GINA guidelines](#) also recommend **Step 1** for MART (Symbicort only))

## CONSIDER DPI FOR MART THERAPY

Ensure routine clinical review at least annually. Review after 6-8 weeks at each step up/down. If asthma uncontrolled, check diagnosis, inhaler technique (and correct if necessary), adherence, use of rescue medication, lung function, exposure to smoking & triggers, side effects and suitability of treatment. **Complete control of asthma is defined as:** no daytime symptoms, no night-time awakening due to asthma, no need for rescue medication, no exacerbations, no asthma attacks, minimal side effects, no limitations on activity including exercise, normal lung function (in practical terms Forced expiratory volume [FEV1] and/or peak expiratory flow [PEF] >80% predicted or best).

## Preventative measures

Consider referral to Pulmonary Rehabilitation (ENHCCG) or Community Respiratory Service (HVCCG) to address dysfunctional breathing or if activity limited by shortness of breath

Ensure administration of annual influenza vaccination

Offer stop smoking support and reinforce benefits

Consider weight loss interventions for overweight adults

## Patient Education

### Personalised Asthma Action Plans (PAAP)

All diagnosed asthma patients should be provided individual, self-management written guidance in the form of a PAAP.

#### Examples from Asthma UK

Should contain:

- Current treatment regime and good inhaler technique
- Symptom triggers and what to avoid to maintain good control.
- Recognising poor control/exacerbations/asthma attacks
- How to increase reliever and maintenance therapy or MART with worsening symptoms and when to start steroids and seek (urgent) medical attention.
- Best PEFR, how to recognise decline and adjust treatment

**PEF >80% best: good control**

**PEF 40-60% best: urgent action: commence oral steroids and seek medical advice**

**PEF <40%: call 999**

### Inhaler Technique

- Provide training on the use of the device and ensure good technique. Consider use of placebo inhaler for training.
- **DPI is the preferred option due to low carbon impact.** pMDI with spacer is as effective. Choice should be based upon patient preference and assessment of correct use.
- Be consistent with device choice (DPI or pMDI); prescribing mixed inhaler can lead to confusion and increased errors
- [Asthma UK OR RightBreathe.com](https://www.rightbreathe.com) for training videos for inhaler technique.
- Use community pharmacy New Medicines Service (NMS) where appropriate.
- **Check adherence with therapy at every opportunity and reinforce technique at every visit.**
- Raise concerns if SABA overuse or underuse of ICS is noted.
- Choose an alternative device if technique remains a problem.

## Drug Delivery

### Spacers

- Improves lung deposition, aids co-ordination, reduces oropharyngeal deposition and local side effects
- Should be compatible with the pMDI being used. See <https://www.rightbreathe.com/> for latest information
- Should be replaced every 12 months
- Should be washed monthly in detergent and allow to air dry

## <sup>1</sup>Asthma components to consider

- Allergy or atopic disease with sensitivity to environmental or occupational triggers e.g. Pollen, pets or dust
- Eczema
- Allergic rhinitis – consider therapy
- Aspirin induced asthma
- Exercise induced bronchoconstriction

## Patient Safety

### Inhaled Corticosteroid Safety

- ICS safety is of crucial importance. Assess benefits versus risks for each individual's needs
- Consider **total daily steroid load**, including intranasal, topical and oral, and assess systemic risk
- Ensure patient is aware of benefits and risks of ICS
- Patients should be maintained at the lowest possible dose of inhaled corticosteroid
- Steroid cards should be issued to patients on high dose ICS (≥ 1000mcg beclomethasone dipropionate (BDP) equivalent daily)
- Local side effects: dysphonia & oral candidiasis - Minimised by use of spacer with pMDI followed by rinsing mouth after inhalation. Systemic side effects of high dose include adrenal suppression, diabetes, skin thinning, bruising, osteoporosis and tuberculosis
- Smoking reduces the effects of ICS; higher doses may be required in smokers and ex-smokers
- Patients receiving 3 or more courses of oral steroid in a 12 month period should be referred to specialists

### Use of Combinations LABA

- Use a combination ICS/LABA in clinical practice to improve adherence and guarantee that LABA is not taken without the ICS.
- Choice of preparation is based upon severity of asthma, device assessment (including carbon impact) and cost.
- Prescribe by BRAND.

## Reconsider diagnosis if....

Reconsider diagnosis if patient is symptomatic despite additional controller therapies (step 3).

Review:

- Eosinophil count
- Immunoglobulin E (IgE)
- Fractional exhaled nitric oxide (FeNO) – (if not available in primary care refer to secondary care)
- Spirometry
- Phenotypes

## ABBREVIATIONS

SABA – Short-acting beta<sub>2</sub> agonist

ICS – Inhaled corticosteroid

LTRA – Leukotriene receptor antagonist

LABA – Long acting beta agonist

LAMA – Long acting muscarinic antagonists

MART – Maintenance & reliever therapy

Version	1.1 Harmonisation of HMMC guidance and WEMOPB guidance update include: Rebadging with HWE ICB and removal of CCG headers. removal of link to CCGs, review date removed and replaced with standard statement
Developed by	HWE ICB PMOT
Approved by /date	HMMC March 2022 and WEMOPB June 2022
Review date	The recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available.