BNSSG Inhaled Steroid Step-Down Protocol in COPD

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

The following protocol describes a process for considering whether withdrawal of inhaled corticosteroids may be safe in patients with COPD with FEV1 ≥40% or ≤80% predicted. Patients with FEV1 >80% predicted should be assessed comprehensively to look at the cause of their symptoms and they therefore fall outside the scope of this guideline. Refer to full BNSSG COPD guideline for more information on COPD management.

Step 1: Optimise COPD Management

Check diagnosis – does the patient have obstructive spirometry? +

No → Consider whether inhaled therapy is still required

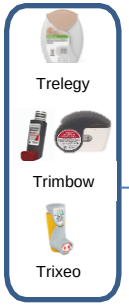
Yes

Step 2: Assess for ICS Step-down

- Does patient have history or features of asthma? + — Yes →
- Does the patient have suggestive features of steroid responsiveness? + — Yes →
- Has patient had ≥2 exacerbations requiring treatment with steroids or antibiotics in the community or ≥ 1 hospitalisation in the last year? — Yes →
- Blood eosinophils 0.3 cells x109 /L (>300µL)* — Yes →

CONTINUE ICS THERAPY

Consider switching to a fixed dose triple combination as per BNSSG COPD Guideline.



No to all the above

Step 3: Stop ICS and switch to LABA/LAMA device that best suits patient's needs. DPIs should be considered first line if clinically appropriate

Dry Powder Inhaler	Metered Dose Inhaler	Soft Mist Inhaler
		
Anoro®, Duaklir®	Bevespi®	Spiolto®

Counsel patient (including safety netting in case of change in symptoms) and arrange follow up

If patients exacerbate or experience a deterioration in symptoms, consider restarting inhaled steroids. Consider use of a fixed dose combination.

Optimise COPD Management

- Has patient been referred for smoking cessation?
- Has pulmonary rehabilitation been offered?
- Has patient been referred for the MyCOPD app?

* Review historical bloods if available. Only review eosinophil level if patient not taking oral corticosteroids when sample taken.

+ If there is uncertainty about an underlying diagnosis of asthma consider reversibility testing. If FEV1 improves by >12% following a bronchodilator, consider a diagnosis of asthma. Asthmatic features suggesting steroid responsiveness in this context include any previous secure diagnosis of asthma or atopy, a higher blood eosinophil count, substantial variation in FEV1 over time (at least 400 ml) or substantial diurnal variation in peak expiratory flow (at least 20%) Consider stepping down dose of ICS if disease well controlled but do not withdraw. If there is uncertainty about whether the patient has significant reversibility in air flow obstruction e.g., asthma/COPD overlap but step down is still being considered, then weaning inhaled steroids over a period should be considered. Alternatively consider further clarification of the correct diagnosis before changing treatment. Patients must always be advised of what to do should they experience a clinical deterioration after step-down.

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