BNSSG Asthma Guidelines 2025 (16 years+)

This document is a distillation of the 2024 *NICE/BTS/SIGN Asthma: diagnosis monitoring and chronic asthma management* guideline available here. Significant advancements in asthma management have been made, introducing a streamlined approach with a single inhaler device throughout treatment. This new approach is **easier, safer and greener**. Please use the links to resources provided for more detailed and local information.

Diagnosis

Ensure correct diagnosis.

See here for the full clinical guideline or PCRS summarised version

Consider Community Diagnostic Centres

Non-pharmacological Asthma Care

Consider social prescribing

Vaccinations

Smoking cessation

Weight loss

Breathing exercises

Singing groups

Medications

See inhaler table on next page

- ☑ Check adherence and inhaler technique **before** stepping up.
- ☑ Dry Powder Inhalers (DPIs) should be used first line where appropriate.
- ☑ RightBreathe website has good inhaler technique videos.
- ☑ All inhalers **must** be prescribed by brand.
- ☑ Spacers should be used with all MDIs. They should be cleaned **monthly** and **replaced every 12 months.** BNSSG preferred spacer is the AeroChamber Plus Flow-Vu

Reviews

Reviews should occur:

a) Annually
b) At exacerbation
c) 8-12 weeks after a medication change

- Reviews should ideally be F2F or via video consultation. Routine phone or desktop reviews are not recommended.

- Every patient **must** have a Personalised Asthma Action Plan (PAAP)

- Review to include; Asthma Control Test, number of exacerbations, time off work/school, OCS use, inhaler technique, adherence, reliever use, trigger factors, smoking/vaping status, rhinitis

- Recheck diagnosis if asthma control remains poor despite good adherence to at least a low dose MART

Refer to secondary care if:

- Diagnostic uncertainty

- Exacerbation requiring hospital admission in the last 12 months

- Asthma remains uncontrolled after 3 months following treatment optimisation

- There is complicating multi-morbidity

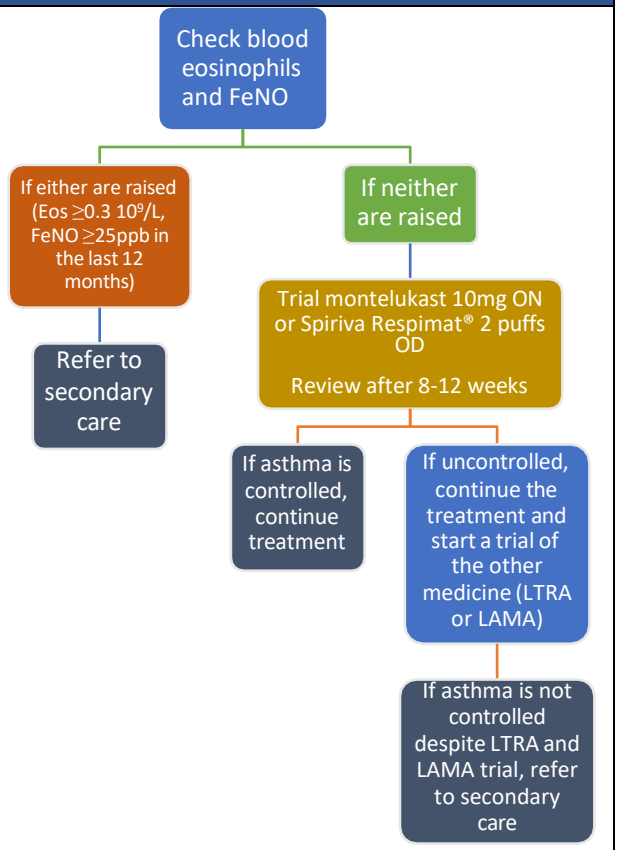
- If ≥2 courses of oral corticosteroids in 12 months, despite optimising medication

Maintenance and Reliever Therapy (MART)

MART is a treatment strategy which combines the use of a single inhaler for both daily maintenance (ICS) and quick relief of symptoms (formoterol). This simplifies treatment, improves adherence and reduces exacerbations. MART is suitable for most patients when education and a PAAP is provided.

Key: SABA = Short-acting β2-agonist ICS = Inhaled corticosteroid LAMA = Long acting muscarinic antagonist LABA = Long-acting β2-agonist LTRA = Leukotriene receptor antagonist

Treatment for people newly diagnosed with asthma

Carbon Footprint Key Low High	Symptoms less than 3 times a week **Anti-inflammatory Reliever (AIR)**	Symptoms most days or waking with asthma once a week or more **Low dose MART**	Daily symptoms or waking with asthma once a week or more and low dose MART is not sufficient despite good adherence **Moderate dose MART** Give steroid emergency card	Daily symptoms or waking with asthma once a week or more where moderate dose MART is not sufficient despite good adherence **Follow flow chart below**
Dry Powder Inhalers (DPI) **First choice if clinically appropriate**	**Fobumix® Easyhaler 160/4.5** (Budesonide/formoterol) 1 puff PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review) **Fostair® 100/6 NEXThaler*▲** (Beclomethasone/formoterol) 1 puff PRN (Max 8 puffs total per day*) **Symbicort® Turbohaler 200/6** (Budesonide/formoterol) 1 puff PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review)	**Fobumix® Easyhaler 160/4.5** (Budesonide/formoterol) 1 puff BD + PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review) **Fostair® 100/6 NEXThaler▲** (Beclomethasone/formoterol) 1 puff BD + PRN (Max 8 puffs total per day*) **Symbicort® Turbohaler 200/6** (Budesonide/formoterol) 1 puff BD + PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review)	**Fobumix® Easyhaler 160/4.5** (Budesonide/formoterol) 2 puffs BD + PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review) **Fostair® 100/6 NEXThaler*▲** (Beclomethasone/formoterol) 2 puffs BD + PRN (Max 8 puffs total per day*) **Symbicort® Turbohaler 200/6** (Budesonide/formoterol) 2 puffs BD + PRN (Max 8 puffs total per day, or 12 puffs for a limited period that should prompt medical review)	
	Within BNSSG Fobumix® is the preferred and most cost-effective DPI. Fobumix® has a 4-month expiry once opened. For patients on AIR therapy only, consider Symbicort®			
Meter Dose Inhalers (MDI) Second choice if DPI not appropriate	**Proxor® 100/6 Inhaler*▲** (Beclomethasone/formoterol) 1 puff PRN (Max 8 puffs total per day*)	**Proxor® 100/6 Inhaler▲** (Beclomethasone/formoterol) 1 puff BD + PRN (Max 8 puffs total per day*)	**Proxor® 100/6 inhaler*▲** (Beclomethasone/formoterol) 2 puffs BD + PRN (Max 8 puffs total per day*)	

*These inhalers are licensed for asthma, but do not have a license for the AIR indication or moderate dose MART however has been agreed to be used by local specialists. ▲These inhalers are licensed for 18 years+.

*Excluding in an exacerbation as directed by the PAAP

Key: SABA = Short-acting β2-agonist ICS = Inhaled corticosteroid LAMA = Long acting muscarinic antagonist LABA = Long-acting β2-agonist LTRA = Leukotriene receptor antagonist

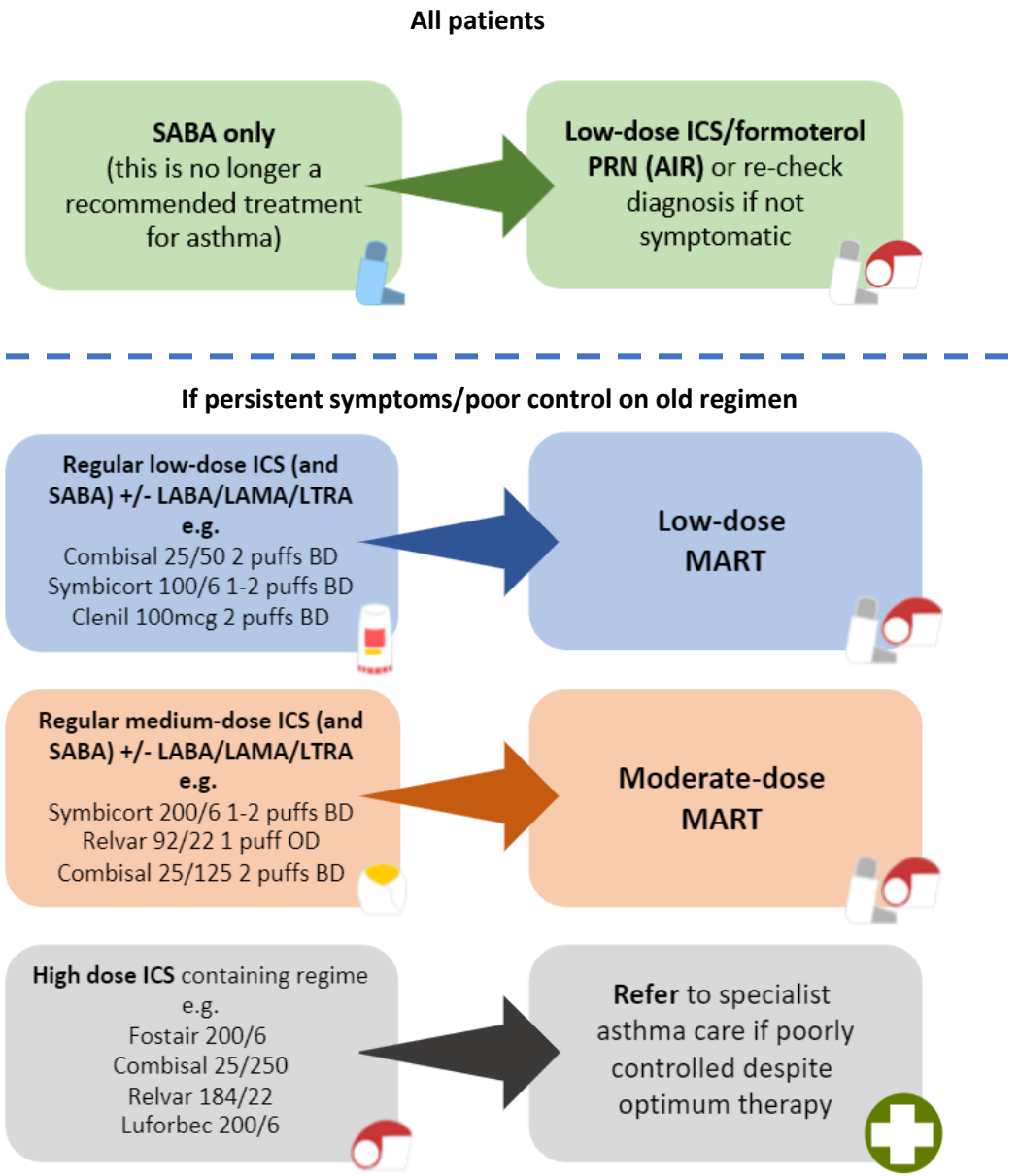
Management and treatment of people with an existing diagnosis of asthma

Key points:

- SABA only: all patients should be switched, or re-check asthma diagnosis if not symptomatic.
- For patients who are not symptomatic and are happy on their current treatment pathway it is **not recommended** that they are switched. Follow EMIS ScriptSwitch messages for BNSSG preferred inhalers.
- Identify adults who are not tolerating their current treatment, particularly where asthma is not controlled. At their next review initiate a discussion with the patient about switching their treatment regime to SABA free (see diagram to right).
- Use tools like SPECTRA and Ardens to support these searches.
- Continuing supplementary therapy (e.g. LTRA, LAMA) should be decided on a case-by-case basis based on the degree of benefit achieved when first introduced.

Stepping Down

- Consider stepping down therapy when asthma is well controlled for a three-month timeframe.
- Discuss the potential risks and benefits of decreasing therapy.
- When reducing maintenance therapy consider clinical effectiveness when introduced, side effects and the person's preference.
- If stepping down in those using low dose ICS alone or low dose MART, step down to low dose ICS/formoterol PRN.
- Agree how the step down will be (self-)monitored, reviewed, and followed-up.
- Review and update the person's asthma action plan.



Key: SABA = Short-acting β2-agonist ICS = Inhaled corticosteroid LAMA = Long acting muscarinic antagonist LABA = Long-acting β2-agonist LTRA = Leukotriene receptor antagonist

Other considerations

Inhaler selection & Environmental Considerations

1. **DPIs** should be offered **first line** where clinically appropriate. Find out how to check whether a patient is suitable for a DPI below.
2. Focus on finding the right medication and device for each individual using shared decision making and ensure good inhaler technique. **Optimal asthma management** is the key goal.
3. Ask patients to **return all used or unwanted inhalers to community pharmacies or dispensaries** for disposal by incineration or re-cycling.
4. See the Greener Practice guide for helpful ways on how to reduce the environmental impact of inhalers

DPI suitability

Most patients will be able to use DPI inhalers but some patients with poor inspiratory ability may struggle to use them. If you are not sure, assess the patient's inspiratory ability by observing them inhaling. As always, inhaler technique is key and so should always be assessed and discussed whichever device is chosen.

- Can the patient take a deep quick breath in within 2-3 seconds? **DPI likely to be fine**
- Can the patient take a slow steady breath in over 4-5 seconds but not a deep quick breath? **MDI may be needed instead of DPI**

Secondary care will be able to:

- Objectively confirm or reject diagnosis of asthma
- Phenotype according to biomarkers
- Assess oral corticosteroid usage and refer to severe asthma MDT for consideration of biologics
- Assess and address suboptimal adherence
- Assess and optimise inhaler technique
- Assess and address relevant co-morbidities including psychosocial factors

Before referring to secondary care, consider the HASTE[2] checklist:

H	A	S	T	E
High intensity treatment	**Adherence**	**Severe exacerbations**	**Technique**	**Exclude other conditions**
Is the patient already at the high-end of the treatment escalator?	Are the patients taking their medication at the correct dose and frequency?	Has the patient had ≥2 courses of oral corticosteroids or been hospitalised due to asthma in the last 12 months?	Is the patient's inhaler technique correct?	Are conditions that mimic or exacerbate asthma being managed?

Key: SABA = Short-acting β2-agonist ICS = Inhaled corticosteroid LAMA = Long acting muscarinic antagonist LABA = Long-acting β2-agonist LTRA = Leukotriene receptor antagonist

Primary Care Respiratory Society[3]: where can I find more information?

Knowledge and training for healthcare professionals in asthma care

- Fit to Care

Diagnosis

- At a glance – FeNO testing in primary care
- Making a business case for FeNO testing in practice
- FeNO in asthma – e-learning programme

Diagnostic tests

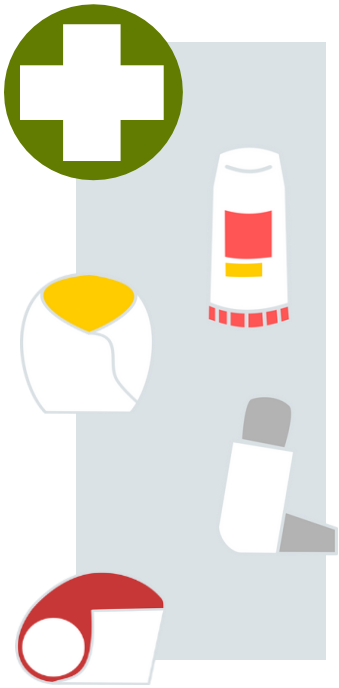
- PCRS Consensus on how to calculate and interpret PEFR variability and reversibility for asthma diagnosis

Treatment

- The GINA approach to managing asthma (AIR) MART top tips article
- Supporting people with asthma in the 21st century online learning. Member only resource
- Ensuring optimal treatment for asthma management
- Tailoring inhaler devices
- Asthma management – tackling SABA overreliance

Monitoring and self-management

- A good asthma review
- Good building blocks of an asthma review
- PCRS tobacco dependency hub
- PCRS MART action plan
- Asthma and Lung UK: AIR action plan
- Calculate the number of reliever inhalers and courses of oral corticosteroids used in the past year - Asthma Slide Rule



References:

1. National Institute for Health and Care Excellence (2024). *Overview | Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/guidance/NG245. [Accessed 3 Jan. 2025].
2. Academic Health Sciences Network. Rapid Uptake Products Asthma Biologics: AAC Consensus Pathway: Management of Uncontrolled Asthma in Adults, June 2022. Available at: https://www.oxfordahsn.org/wpcontent/uploads/2022/06/AAC-Pathway-16.9_FINAL-No-NHS.pdf. [Accessed 3 Jan 2025]
3. Pcrs-uk.org. (2024). *First steps to implement the new BTS/NICE/SIGN asthma guideline | Primary Care Respiratory Society*. [online] Available at: https://www.pcrs-uk.org/resource/current/first-steps-implement-new-btsnicesign-asthma-guideline [Accessed 3 Jan. 2025].

BNSSG Medicines Optimisation team with NBT, UHBW and BNSSG Respiratory Working Group
Approved by BNSSG Area Prescribing and Medicines Committee March 2025 (Minor amendment Aug 25).
Review March 2028

Key: SABA = Short-acting β2-agonist ICS = Inhaled corticosteroid LAMA = Long acting muscarinic antagonist LABA = Long-acting β2-agonist LTRA = Leukotriene receptor antagonist