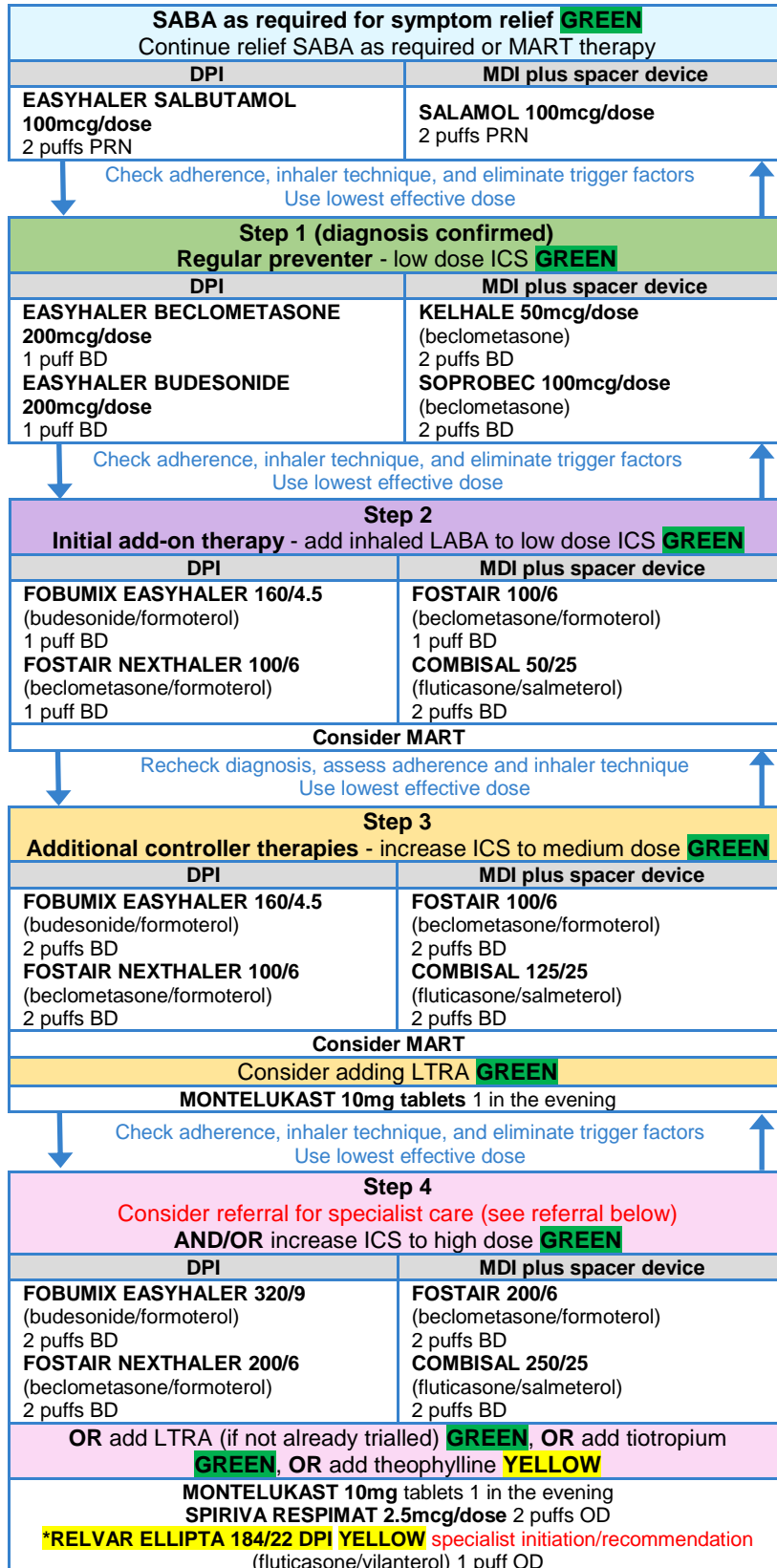


ADULT ASTHMA TREATMENT GUIDELINES (18 years and over)

Treatment guidelines and formulary inhaler choices for the treatment of adult asthma. Prescribe inhalers by brand name to ensure continuity of inhaler device. **Prescribers and patients should be aware that there are significant differences in the global-warming potential of different devices and that inhalers with low global-warming potential such as DPIs listed below should be used when they are likely to be equally effective as MDIs.** Please refer to the [NICE patient decision aid-inhalers for asthma](#) to facilitate discussions on appropriate inhaler devices for patients.



Start treatment at the step most appropriate to the initial severity of asthma

Consider ICS in any of the following:

- asthma attack in the last two years
- using inhaled SABA three times a week or more
- symptomatic three times a week or more
- waking one night a week

KELHALE (equivalent to QVAR) contains extra-fine particles of beclometasone and is approximately twice as potent as **SOPROBEC** (equivalent to CLENIL)

***RELVAR ELLIPTA 92/22 and 184/22: YELLOW specialist initiation/recommendation**

Maintenance and reliever therapy (MART)

- Single combination inhaler for maintenance and reliever therapy.
- Consider MART if a history of asthma attacks on low/medium dose ICS/LABA.
- **FOBUMIX EASYHALER 160/4.5 MART:** 1 to 2 puffs BD and 1 puff PRN (not more than 6 puffs at once), maximum 8 puffs/day (up to 12 puffs/day for a limited period with urgent review).
- **FOSTAIR 100/6 and FOSTAIR NEXTHALER 100/6 MART:** 1 puff BD and 1 puff PRN, maximum 8 puffs/day.
- MART requires careful patient education and quantity of inhalers used should be monitored.
- Patients taking rescue doses of their combination inhaler once a day or more on a regular basis should have their treatment reviewed.
- **COMBISAL and RELVAR ELLIPTA:** no MART license.

DPI: dry powder inhaler
MDI: metered dose inhaler
OD: once daily
BD: twice daily
PRN: when required
SABA: short acting beta-2 agonist
LABA: long acting beta-2 agonist
ICS: inhaled corticosteroid
LTRA: leukotriene receptor antagonist

GREEN: recommended for primary care or secondary care initiation and primary care continuation.

YELLOW: recommended for specialist initiation and primary care continuation with appropriate information from specialist, or following specialist recommendation including via advice and guidance request.



Aim of Treatment

The aim of asthma management is complete control of asthma, defined as:

- no daytime symptoms
- no night time awakening due to asthma
- no need for rescue medication
- no asthma attacks
- 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

Stepwise Approach

- Start treatment at the step most appropriate to initial severity.
- Achieve early control and maintain control by:
 - stepping up treatment as necessary
 - stepping down treatment when control is good
- Before initiating a new drug or changing therapy, check adherence with existing treatments, check satisfactory inhaler technique and eliminate trigger factors.

Stepping down

- Patients should be maintained at the lowest effective dose of ICS to achieve control.
- Review stable patients and consider reducing ICS dose every 3 months by approximately 25% to 50% each time.
- After treatment is stepped down the patient should have their treatment reviewed within 6-8 weeks.

Regular review and assessment

- Clinical review at least annually, or more frequently where appropriate.
- Assess asthma symptom control using specific questions, such as the Royal College of Physicians' '3 Questions' or questions about frequency of reliever/SABA use. Positive responses should prompt further assessment with a validated questionnaire to assess symptom control such as the Asthma Control Test (ACT): <http://www.asthmacontroltest.com/>.
- Review high use of SABA inhalers (6 inhalers or more in 6 months requires urgent review) which is associated with an increased risk of asthma death, particularly when adherence to ICS is low (National Review of Asthma Deaths).

Education

- Assess inhaler technique, check adherence and eliminate trigger factors regularly and before a change in treatment.
- For training videos and inhaler information, Asthma UK: www.asthma.org.uk and RightBreathe: www.rightbreathe.com.
- Provide and update an agreed personalised asthma action plan (PAAP) that the patient understands and will use, including step up and step down advice, and when to seek medical advice (www.asthma.org.uk).
- Provide a steroid card to patients receiving high dose ICS and consider a steroid card for patients receiving medium dose ICS.
- Offer support and advice on smoking cessation and weight management as appropriate.
- Offer annual influenza vaccination, unless contra-indicated.

Spacer devices

- MDIs should be used with a spacer to improve lung deposition, aid co-ordination, and reduce oropharyngeal deposition and local side effects.
- Recommended spacer devices compatible with the following formulary MDIs:
 - EasyChamber spacer (anti-static - no need to wash before first use): compatible with Salamol, Kelhale and Fostair
 - Volumatic spacer (wash before first use and allow to air dry to reduce static): compatible with Salamol and Soprobec
 - AeroChamber Plus spacer (wash before first use and allow to air dry to reduce static): compatible with Combisal
- Replace spacer devices at least every 12 months but some may need changing at 6 months.
- Spacer devices should be cleaned monthly in detergent and allowed to air dry.

Referral

Biologic therapies are showing excellent benefits in reducing the burden of oral steroids in patients with severe asthma. Referral to secondary care should be considered for patients with poor control of symptoms at step 4. Patients with frequent exacerbations requiring oral steroids are most likely to benefit from biologic therapy and these patients should be targeted for referral.

References	BTS/SIGN British guideline on the management of asthma (First published 2003, revised edition published July 2019): https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/ PrescQIPP Lowering the inhaler carbon footprint data tool: https://www.prescqipp.info/news/lowering-the-inhaler-carbon-footprint-data-tool/ Drug Tariff online (May 2021): https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff MIMS online, Table: Asthma and COPD Preparations and Compatible Devices: https://www.mims.co.uk/table-asthma-copd-preparations-compatible-devices/respiratory-system/article/1427948 MIMS online, Table: Combination Inhalers for the Treatment of Asthma: https://www.mims.co.uk/table-combination-inhalers-treatment-asthma/respiratory-system/article/1519264 NICE patient decision aid-inhalers for asthma: https://www.nice.org.uk/guidance/ng80/resources/inhalers-for-asthma-patient-decision-aid-pdf-6727144573 NICE Guideline Asthma: diagnosis, monitoring and chronic asthma management, NG80 (November 2017): https://www.nice.org.uk/guidance/ng80 John White, James Y Paton, Robert Niven, Hilary Pinnock. Guidelines for the diagnosis and management of asthma: a look at the key differences between BTS/SIGN and NICE. <i>Thorax</i> . 2018;73:293–297: https://thorax.bmj.com/content/thoraxjnl/73/3/293.full.pdf
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This MSEMOC recommendation is based upon the evidence available at the time of publication. The recommendation will be reviewed upon request in the light of new evidence becoming available.