

Primary Care Medicines Management of Stable COPD

Confirmed diagnosis of COPD

Review Date May 2026

Non pharmacological management

Treat tobacco dependency, offer flu ,COVID and pneumococcal vaccination, optimise BMI, optimise treatment for co-morbidities eg heart failure and ischaemic heart disease, promote exercise, assess symptoms using MRC / CAT Test and refer to pulmonary rehabilitation if appropriate.

Patients should have an agreed COPD self-management plan

Pulmonary rehabilitation should be considered and discussed with patient at all stages of disease progression when symptoms and disability are present and not at a predetermined level of impairment. Motivate patient to attend. The threshold for referral would usually be breathlessness equivalent to MRC dyspnoea grade 3.

Inhaled therapies

- Prescribe inhalers only after the patient has received training in the use of the device and can demonstrate satisfactory technique
- Before any change of therapy assess adherence and inhaler technique

Offer SABA or SAMA to use as needed if occasional breathlessness

Person still limited by breathlessness, exercise limitation or has exacerbations

No eosinophilic phenotype or reversibility on spirometry. Day to day symptoms adversely impacting quality of life

No eosinophilic phenotype or reversibility on spirometry. Had ≤ 1exacerbation +/- breathlessness

Eosinophilic phenotype , more than 2 exacerbations or features suggesting steroid responsiveness

Offer LABA+LAMA

-Consider LAMA monotherapy if dual therapy is not tolerated or contra-indicated
- GOLD² recommends monotherapy for patients with few symptoms and few exacerbations.
NB Patients currently using single therapy LAMA or LABA and symptoms are under control; continue with this until they and their health care professional agree it is appropriate to change.

Consider LAMA+LABA+ICS

Be prepared to discuss with the person, the risk of side effects (including pneumonia) in people who take ICS for COPD

Still limited by symptoms

1 severe or 2 moderate exacerbations/ year

Still limited by symptoms or exacerbations

STOP, THINK, TAKE STOCK

Be aware of the increased risk of side effects including pneumonia in people who take ICS

See box on P.2 for information from GOLD² supporting ICS use

Before starting LAMA+LABA+ICS, conduct a clinical review to ensure:

- non-pharmacological COPD management is optimised as above
- the patient has been offered treatment for tobacco dependence if they smoke
- worsening symptoms and/or the symptoms adversely impacting on the patient's quality of life are caused by COPD and not by another physical or mental health condition
- be prepared to discuss with the person, the risk of side effects (including pneumonia) in people who take ICS for COPD
- Triple therapy LAMA+LABA+ICS should be prescribed as a single inhaler

Consider

3-month trial of LABA+LAMA+ICS (in a triple inhaler)
If after 3 months symptoms have not improved STOP and switch back to LAMA+LABA

If LAMA+LABA+ICS consider concurrent asthma and refer to [Frimley asthma guidelines](#)

If patient is still symptomatic refer to specialist

Prophylactic antibiotics eg Azithromycin may be started by a respiratory specialist and continued in primary care. Phosphodiesterase-4 inhibitors: Roflumilast may be started by a specialist and continued in primary care

Patients on triple therapy: document the reason for continuing ICS use in clinical records and review at least annually

Key SABA short acting beta 2 agonist
SAMA short acting muscarinic antagonist
LAMA long acting muscarinic antagonist
LABA long acting beta 2 agonist
ICS inhaled corticosteroid
pMDI pressurised metered dose inhaler
DPI dry powder inhaler

Diagnosis of COPD

Refer to [NG 115](#) and [GOLD Report 2024](#). There is no single diagnostic test for COPD. Making a diagnosis relies on clinical judgement based on a combination of history, physical examination, and confirmation of the presence of airflow obstruction.

Eosinophilic phenotype, spirometry reversibility, steroid responsiveness

- Previous history of asthma/ atopy
- Significant symptom variability
- Night time waking with breathlessness and/or wheeze
- A higher blood eosinophil count (>300 cells /ul)
- Variation in FEV1>400ml or serial peak flow >20% consider concurrent asthma

Inhaler devices

Prescribe by brand name only

- With the patient, decide the best device for them – can they use it? is it suitable?
- Spacer device with MDI improves co-ordination, increases lung deposition, reduces local side effects. Requires slow, gentle, long inhalation.
- DPI reduces carbon footprint, needs less co-ordination and requires deep forceful inhalation.
- Video and patient leaflets for inhaler technique access [here](#)
- Use an In-Check dial for assessment of inspiratory flow and to aid inhaler technique training

Mucolytics Patient with chronic cough productive of sputum: consider 6-8 week trial of carbocisteine 750mg tds, review and reduce to 750mg bd after 6-8 weeks if response. Stop if no reduction in cough /sputum.

Nebulisers should not be seen as an easy alternative for patients unable to acquire and/or attain adequate inhaler technique. Patients should be referred to local respiratory care team for formal assessment

Long Term Oxygen Therapy (LTOT)

Refer patients to local Respiratory Care Team for formal assessment

- COPD and oxygen sats ≤ 92%
- Cyanosis, polycythaemia, peripheral oedema, raised jugular venous pressure and oxygen sats ≤ 94 %.

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Formulary	Green = Low carbon footprint inhaler choices	For information on traffic light status of available inhalers see: Frimley Formulary Frimley COPD formulary inhaler poster	
Brand	Device	Drug	Dose
SABA /SAMA			
Salbutamol Easyhaler®	DPI	Salbutamol 100 mcg	2 puffs prn
Ventolin Accuhaler®	DPI	Salbutamol 200mcg	1 puff prn
Salamol MDI*	pMDI†	Salbutamol 100 mcg	2 puffs prn
LAMA			
Seebri Breezhaler®	DPI	Glycopyrronium 44mcg	1 puff od
Incruse Ellipta®	DPI	Umeclidinium 55mcg	1 puff od
Eklira Genuair®	DPI	Acclidinium 322mcg	1 puff bd
Spiriva Respimat®**	Soft Mist	Tiotropium 2.5mcg	2 puffs od
LAMA/LABA			
Ultibro Breezhaler®	DPI	Glycopyrronium/indacaterol 85/43	1 puff od
Anoro Ellipta®	DPI	Umeclidinium/vilanterol 55/22mcg	1 puff od
Duaklir Genuair®	DPI	Acclidinium/formoterol 340/12	1 puff bd
Spiolto Respimat®**	Soft Mist	Tiotropium/olodaterol 2.5/2.5mcg	2 puffs od
Bevespi Aerosphere	pMDI†	Glycopyrronium/formoterol 7.2/5	
LABA/LAMA/ICS			
Trelegy Ellipta®	DPI	Fluticasone furoate/umeclidinium vilanterol 92/55/22	1 puff od
Trimbow Nexthaler®	DPI	Beclometasone/formoterol glycopyrronium 87/5/9	2 puffs bd
Trimbow MDI®	pMDI†	Beclometasone/formoterol glycopyrronium 87/5/9	2 puffs bd
Trixeo Aerosphere®	pMDI†	Budesonide/formoterol/glycopyrronium 160/5/7.2	2 puffs bd

Medication Review

Mild/moderate COPD –annual
Severe/very severe - **twice yearly**

- Develop an individualised self management plan and review at future appointments. [See Asthma + Lung UK here](#)
- Check inhaler technique and adherence at each review and before starting a new inhaler.
- Review symptom control, activities of daily living and number of exacerbations in past 12 months.
- Use MRC dyspnoea scale or access [Cat Test](#) to assess symptoms.
- Discuss physical activity and pulmonary rehabilitation if appropriate (threshold usually MRC grade3)
- Advice on quitting smoking
- Vaccinations [The Green Book](#)
- Identifying and managing exacerbations (see below)

Community Pharmacy

- New Medicines Service (NMS) for patients newly prescribed inhalers. Patient leaflet [here](#).
- Inhalers should be returned to the community pharmacy for safe environmentally friendly disposal.

*Salamol MDI is a small volume branded salbutamol MDI with a lower carbon footprint than large volume MDI.

**Respimat is available as a re-usable device

†Use spacer device with pMDI

Initiation of ICS treatment in combination with long-acting bronchodilators

Information from [GOLD Report Strong Support](#)

History of hospitalisation /exacerbation of COPD
Two or more moderate exacerbations of COPD per year

Blood eosinophils > 300 cells/ul*

History of concomitant asthma

Against use

Repeated pneumonia events

Blood eosinophils <100 cells/ul*

History of mycobacterial infection

**Quoted values represent approximate cut off points. This may differ according to local protocols*

Inhaler Choice and Carbon Footprint

- Use [NICE patient decision aid](#) to help the patient decide which inhaler is easiest to use
- [Environment and lung health | British Thoracic Society](#)
- Complete elimination of pMDIs may not be possible due to preference and the need for sufficient inspiratory flow to activate DPIs. However, BTS encourages use of DPIs when they are likely to be equally effective.
- Prescribe inhalers only after the patient has received training in the use of the device and can demonstrate satisfactory technique.
- Patient leaflets for inhaler technique and video training resources are available [here](#)

Exacerbations of COPD

For detailed information including treatment of more complex patients [NG 115](#) and [GOLD Report](#)

- Develop an individualised exacerbation plan with each person with COPD who is at risk of exacerbations. Encourage patient to respond promptly to symptoms:
 - -This may include stepping up bronchodilator therapy
 - -Starting antibiotic therapy if sputum changes colour, increases in volume or thickness more than normal.
 - -A short course of oral corticosteroids if their increased breathlessness interferes with activities of daily living
- If they have had an exacerbation in the past year and remain at risk offer a short course of antibiotics and oral corticosteroids (COPD Rescue Pack) to keep at home as part of their plan.
- [South Central Anti-microbial Network \(SCAN\)](#)
- [Frimley ICB COPD rescue patient leaflet](#)
- **Antibiotics**
- Amoxicillin 500mg three times daily for 5 days **or**
- Doxycycline 200mg on first day, then 100mg once a day for 5-days in total **or**
- Clarithromycin 500mg bd for 5 days
- **Oral Corticosteroid**
- Offer 30mg oral prednisolone daily for 5 days.
- Check patient understands when and how to take the medicines, associated risks, and harms.
- Patient to advise their health care professional when they start the rescue pack and to be invited for review.
- For people who have used 3 or more courses of the rescue pack in the last year investigate the possible reasons.