

STEPWISE MANAGEMENT OF STABLE COPD

| | | Increasing COPD severity | | |
|--|--|--|---|--------|
| | | MILD | MODERATE | SEVERE |
| Typical symptoms | <ul style="list-style-type: none"> few symptoms breathless on moderate exertion little or no effect on daily activities cough and sputum production | <ul style="list-style-type: none"> breathless walking on level ground increasing limitation of daily activities recurrent chest infections exacerbations requiring oral corticosteroids and/or antibiotics | <ul style="list-style-type: none"> breathless on minimal exertion daily activities severely curtailed exacerbations of increasing frequency and severity | |
| Typical lung function | FEV₁ ≈ 60-80% predicted | FEV₁ ≈ 40-59% predicted | FEV₁ < 40% predicted | |
| CONFIRM diagnosis. Confirm post-bronchodilator airflow limitation (FEV ₁ /FVC <0.70) using spirometry . Any pattern of cough with or without chronic sputum production may indicate COPD. | | | | |
| OPTIMISE function. PREVENT deterioration. DEVELOP a plan of care. | | | | |
| Non-pharmacological interventions | REDUCE RISK FACTORS Avoid exposure to risk factors including tobacco smoke and air pollution, support smoking cessation, recommend annual influenza vaccine and pneumococcal vaccine according to immunisation handbook | | | |
| | OPTIMISE FUNCTION Encourage regular exercise and physical activity, review nutrition, provide education, develop GP management plan and written COPD action plan (and initiate regular review) | | | |
| | OPTIMISE TREATMENT OF CO-MORBIDITIES especially cardiovascular disease, anxiety, depression, lung cancer and osteoporosis | | | |
| | REFER symptomatic patients to pulmonary rehabilitation | | | |
| | | INITIATE advanced care planning | | |
| | | | MANAGE advanced lung disease with domiciliary oxygen therapy, long-term non-invasive ventilation, surgery and bronchoscopic interventions, if indicated | |
| Pharmacological interventions (inhaled medicines)** | START with short-acting relievers: (used as needed): SABA (short-acting beta ₂ -agonist) OR SAMA (short-acting muscarinic antagonist) | | | |
| | ADD long-acting bronchodilators: LAMA (long-acting muscarinic antagonist) OR LABA (long-acting beta ₂ -agonist) Consider need for combination LAMA/LABA depending on symptomatic response | | | |
| | | CONSIDER adding ICS (inhaled corticosteroids): Single inhaler triple therapy (ICS/LABA/LAMA) may be suitable* | | |
| *in patients with ≥1 severe exacerbation requiring hospitalisation or ≥2 moderate exacerbations in the previous 12 months, AND significant symptoms despite LAMA/LABA or ICS/LABA therapy; OR in patients stabilised on a combination of LAMA, LABA and ICS. | | | | |
| Assess and optimise inhaler device technique at each visit. Minimise inhaler device polypharmacy | | | | |

REFER PATIENTS TO LUNG FOUNDATION AUSTRALIA FOR INFORMATION AND SUPPORT - FREECALL 1800 654 301

Lung Foundation Australia has a range of resources to promote understanding of COPD and assist with management.

Based on The COPD-X Plan: Australian and New Zealand Guidelines for the Management of COPD and COPD-X Concise Guide

**Refer to PBS criteria: www.pbs.gov.au

Access a copy of the COPD inhaler chart, featuring PBS listed medicines approved for use in COPD.



Lung Foundation Australia

1800 654 301 | Lungfoundation.com.au