Clinical Effectiveness
Southwark

QUAY HEALTH SOLUTIONS ihl NHS Southwark Clinical Commissioning Group The Health Foundation

# COPD in the context of COVID-19

## A guide for Southwark General Practice©

**Key Messages:**

1) **Spirometry is not currently recommended at practice level (aerosol generating), use peak-flows** (at home) instead and refer into community diagnostic hub (when available)

2) **Patients with COPD are at a high risk of adverse outcomes from COVID pneumonia:** optimise medical management in pre-winter window

3) **Oral cortico-steroids should be <u>avoided</u> in COVID suspected infection (which presents differently to a COPD exacerbation).** For an exacerbation, oral cortico-steroids can be considered as usual e.g. if with concomitant asthma/steroid responsiveness/eosinophils >0.3

Always work within your knowledge and competency

December 2020

# Differentiating between respiratory symptoms

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| | COVID-19 | Exacerbation of COPD | Flu | Community-acquired bacterial pneumonia |
|---|---|---|---|---|
| Fever | +++ | + | +++ | +++ |
| Cough | +++ | ++ | ++ | + |
| Fatigue | +++ | Related to disease severity | ++ | ++ |
| Dyspnoea | +++ | +++ | + | Varies with age |
| Sputum production | + | +++ | Dry | Purulent |
| Wheeze | | ++ | | + |
| Other symptoms | Anosmia<br>Pleuritic pain (beware pulmonary embolus) | Can desaturate on exertion when well | | Pleuritic pain (but related to pneumonia) |
| Time to symptoms | Typically 5-6 days, but can be up to 14 days | 2-4 days | 1-4 days | Rapid progression |

With thanks to Dr Irem Patel for this slide
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# Principles of COPD management in the context of COVID

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## Diagnosing COPD

**Spirometry is NOT recommended at practice level** as it is aerosol generating – use **PEFR (at home)** for assessment and **refer** to community hub.

Consider video consult to show/check PEFR technique.

## How to diagnose using PEFR

Serial measurements over two weeks. COPD diagnosis is supported by PEFR:

- <75% predicted
- <20% variability
- Remains low despite use of salbutamol
- Plus a supporting clinical history

## What next?

For patients with suspected COPD use an empirical trial of dual bronchodilator therapy (LAMA/LABA) (or ICS/LABA if history of exacerbations (>2/year), features of asthma-COPD over-lap, or eosinophils>0.3)

Use community hub spirometry to confirm diagnosis when available

**In interim: code as 'suspected COPD' and code 'spirometry not done' to allow you to search for these patients and organise spirometry when it is available**

If any doubt, consultant connect/advice and guidance (A&G)

## Optimising COPD

COPD patients are at high risk of adverse outcomes from COVID pneumonia, and if severe COPD (FEV1 <50%) they are extremely vulnerable

Other factors that worsen risk: previous admission, LTOT/NIV, limiting breathlessness, frailty and multi morbidity

## Reduce risk of exacerbation

**Don't forget the basics:**

- smoking cessation
- flu vaccination
- pulmonary rehab (click for online patient resource)

**Optimise medical management in pre-Winter window**

- COPD pro-active review including a COPD plan & rescue pack (see CES COPD guide page 14)

## Inhaled corticosteroids

There **is no evidence that treatment with inhaled corticosteroids (ICS)** for COPD either protects or increases the risk associated with COVID

**ICS step-down in COPD:**

- **Refrain from making changes to preventer therapy during a wave**
- Wait until the wave of COVID illness is waning and a more normal way of working has resumed

**Abbreviations**

ICS – inhaled corticosteroid
LABA – long acting beta-agonist
LAMA – long-acting muscarinic antagonist
LTOT – long-term oxygen therapy
NIV – non-invasive ventilation
PEFR – peak expiratory flow rate

# Treating an exacerbation of COPD vs Suspected COVID

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## Oral corticosteroids (OCS)

OCS should be avoided in COVID suspected infection (e.g. new cough/fever/myalgia, which presents differently to an exacerbation) (see page 2)

**Otherwise, treat with OCS (as per usual) if clinically appropriate if COPD exacerbation suspected i.e. more breathless and wheezy (interfering with activities of daily living), with**

- known concomitant asthma +/- history of eosinophils ≥ 0.3 OR
- known steroid responsiveness

**Before prescribing steroids, advice:** increased bronchodilation, breathing exercises and pacing, where appropriate.

## Oral Antibiotics

**Do not offer an antibiotic** for treatment/prevention of pneumonia if COVID is likely to be the cause **and** their symptoms are **mild**.

**Offer an oral antibiotic (see antibiotic guidance or CES guidance here ) for treatment of pneumonia in people who can or wish to be treated in the community if:**

- the likely cause is **bacterial** or
- it is **unclear** if the cause is bacterial or viral and symptoms are more concerning or
- they are at **high risk of complications**

## Care planning

**For those with the most severe COPD** – now is the time to have those important conversations about preferred place of care and which treatments or interventions would be right for this patient.

Check to see if the patient has a **'Coordinate My Care'** record completed by the respiratory team. A conversation in crisis may result in transfer to a stressed hospital environment where loved ones cannot be present.

## Assessing need for hospitalisation

**See COVID pathway (page 4) regarding physiological parameters**

**But if baseline saturations are available:**

- **Mild deterioration -** up to **2% below** their baseline/target saturations
- **Moderate deterioration** - **3-4% below** their baseline/target saturations
- **Severe deterioration** - more than **4% below** their baseline/target saturations

**If on Long Term Oxygen Therapy (LTOT):** discuss ceiling of care, seek advice from the integrated respiratory team and consider admission if sats <88% on their standard dose of LTOT

# Need help of advice?

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**Urgent telephone advice**

- Consultant Connect: Respiratory
- COPD clinical advice lines: GSTT call 07796 178719, KCH 0203 299 6531 (7 days/week 9am-445pm) [for general COPD advice, but also for advice about patients under the care of the IRT]

**Urgent referrals @Home team Southwark:**

8am -11pm call 0203 049 5751, email medical summary thereafter to gst-tr.gsttathome@nhs.net , for further information, see

**Non-urgent advice**

- **'Advice & Guidance'-** COPD clinic GSTT, or Respiratory clinic at KCH
- **Virtual Respiratory Clinic** (cover both Asthma and COPD)– run by Dr Irem Patel Respiratory Consultant, KCH and Dr Amy Dewar Respiratory Consultant, GSTT. To organise, contact 0203 299 3103 or email Stu: s.lindsey@nhs.net . Clinics are available Mondays, Tuesdays, Thursdays and Fridays between 2pm and 4pm. One/practice/year. You will be emailed instructions about how to book slots/how many patients etc

**Routine Referrals**

- **Integrated Respiratory Team (IRT): COPD patients with complexity**
  The IRT can provide a holistic review and home visit if needed. Referral - GSTT: gst-tr.integratedrespiratoryteamgstt@nhs.net, or call 07796 178719, KCH kch-tr.IntegratedRespiratoryTeam@nhs.net, or call 0203 299 6531 (7 days/week 9am-445pm)
- **COPD Clinics:** Via eRS COPD Clinic at GSTT, or Respiratory Clinic at KCH

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References:
This update builds on best-practice guidance previously set out in CES Guide for COPD.

Guidance that informs this update is available here:
PCRS Pragmatic Guidance (7/5/2020)
Diagnosing and managing asthma attacks and people with COPD presenting in crisis during the UK Covid 19 epidemic

COVID-19 rapid guideline: community-based care of patients with chronic obstructive pulmonary disease (COPD)
NICE guideline [NG168] Published date: 09 April 2020

A comprehensive set of Covid-19 support guidance can be accessed at https://selondonccg.nhs.uk/covid-19-clinical-support/
If your practice is interested in receiving further support/a virtual visit from the CES team please email souccg.clinicaleffectiveness@nhs.net

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