

Reducing Unscheduled Admissions COPD

Identify

Proper inhaler use

Imms

Pulmonary Rehab if an exacerbation

O2 if indicated by sats below 92%

COPD Diag

Occupation

Cigarette History

Spirometry Ratio fev1/FVC > then FEV1 to assess severity

Chest X not diagnostic

2 types 1 Cough spit type [bronchitis]

2 Breathless type [emphysema]

Exacerbation= increase in breathlessness+ increase in spit+change in colour

Rx Ab Amoxil Doxycycline Coamoxiclav not Cefalexin or Ciproxin

Pred

Nebs

O2 if sats indicate need

Asthma Assessment

3 questions RCP questions

Inhaler technique check

PEF

Don't step down sooner than 4-6 months

Asthma Diag

Cough Wheeze Dyspnoea

Increased dyspnoea at night or on exertion or in cold air or after taking aspirin or NSAID or Beta Blocker

Presence of Eczema Hayfever or FH of

Wheeze heard on listening to chest

Increased eosinophils in FBC

Suspect other diag if continuous cough cigarettes no wheeze or PEF normal

Diags include COPD Bronchiectasis Heart failure

Refer if

Occupation suspected

Persistent rather than episodic dyspnoea

Other sympts/signs present

Chest X shows shadow

Increased Eosinophils [possible vasculitis]

Poor response to treatment

Inhaler Technique

MDI nearly hopeless without spacer

Dry Powder Inhaler [e.g. Accuhaler Turbohaler Easyhaler] patients breathe too slowly as increased resistance. Also severe COPD can't inhale it

Breath Actuated MDI [e.g. easibreathe] good

Using MDIs

Shake before use

Space 30 secs between puffs as puffer cools and aerosol is not formed properly

If using several puffs via spacer do one at a time not all at once

Hold breath after each inhalation to improve deposition

Spirometry Contraindications

MI within 4 weeks or Unstable Angina

Pulmonary Embolus

Aneurysm in Head or Thorax or Abdomen

Recent Eye Operation

Coughing Blood [could have TB and contaminate spirometer]

Notes on Interpreting Spirometry

Low VC there is difficulty differentiating severe Obstruction from Restriction they look the same

Elderly with low FVC must be breathless to count as COPD

O2

LTOT if permanently hypoxic

SBOT of little value

AOT if hypoxic in exertion

Use in Lung Conditions and Cardiac failure

Sat > 92% COPD

Sat >94% Other things

Do Blood gases

PO₂ < or = 7.3 KPa

Do Spirometry

Arrange Pulmonary Rehab

Give for 15h/day using night time to clock up required hours

Don't Rx O₂ in GP arrange for HOOF team to do it all.