

Rapid Uptake Products Asthma Biologics

AAC Consensus Pathway: Management of Uncontrolled Asthma in Adults Overview

June 2022



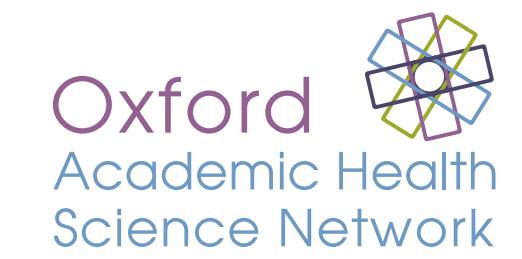
In Partnership with:



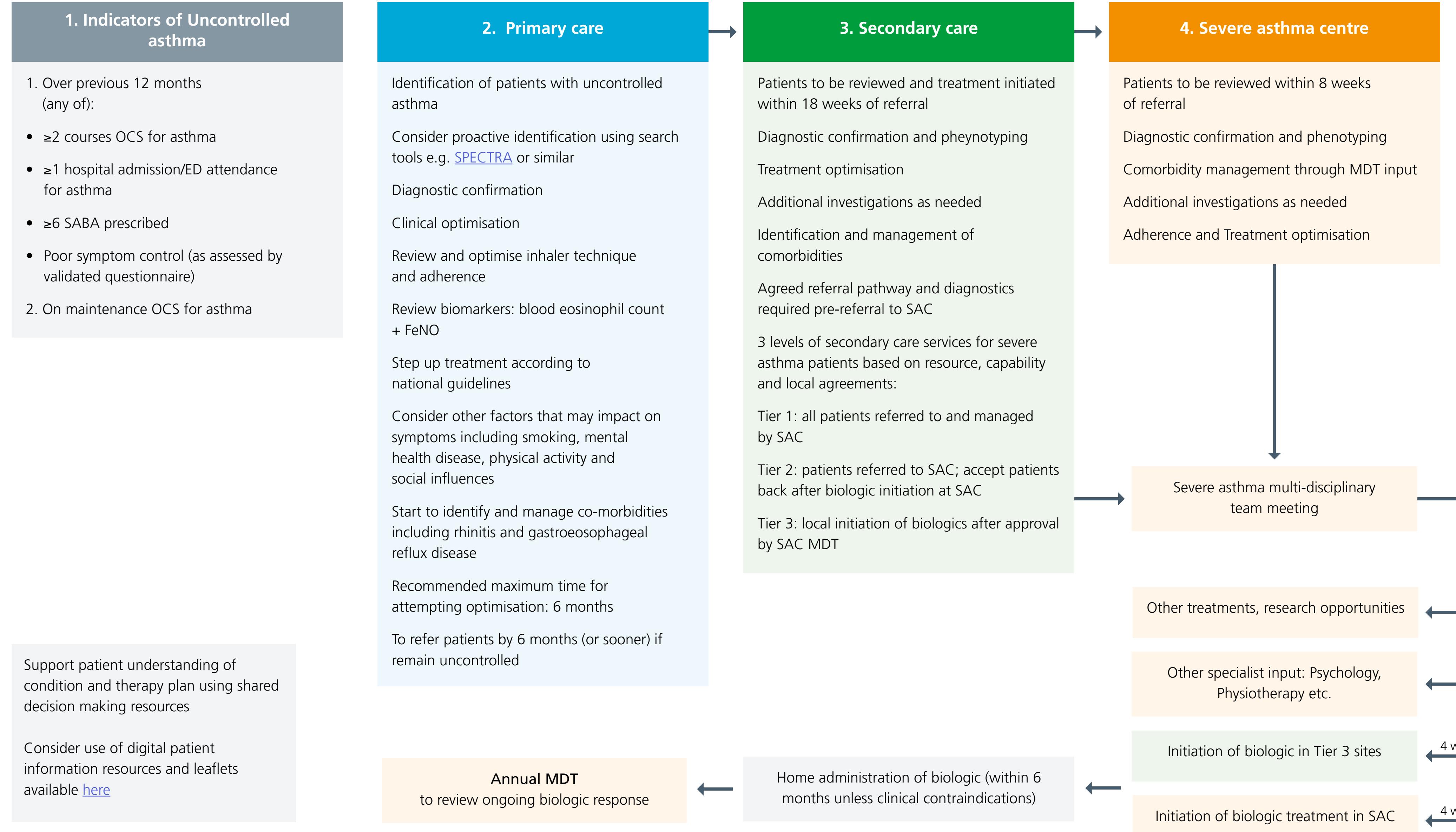
British
Thoracic
Society



ARNS
Association of Respiratory
Nurse Specialists



Oxford
Academic Health
Science Network



Acronyms:

OCS - Oral corticosteroid
ED - Emergency department

SABA - Short-acting beta-agonist
FeNO - Fractional exhaled nitric oxide

SAC - Severe asthma centre
MDT - Multi-disciplinary team

Consensus Overviews: Primary Care

5. Identifying Uncontrolled Asthma

5.1. Indicators of Uncontrolled Asthma:

- Frequent exacerbations (≥ 2 /year) requiring oral steroids, or serious exacerbations (≥ 1 /year) requiring hospitalisation or ED attendance
- Poor symptom control (frequent symptoms/reliever use, night waking due to asthma, activity limited by asthma), as identified through the use of a validated, objective symptom questionnaire (ACT, ACQ)
- 6 or more SABAs in a 12-month period

5.2. Identifying patients with uncontrolled asthma

Patients can be identified at any time but the 3 main opportunities are:

1. At the time of the annual review
2. Exacerbation visit/ post exacerbation review –
 - Ensure mechanisms in place to support identification and follow up of patients admitted to ED with asthma exacerbations
3. Proactive case-finding through interrogation of electronic patient records:
recommend to carry out every 6 months

Consider direct referral to SAC:

- If on maintenance steroids for asthma
 - Maintenance OCS: ≥ 5 mg prednisolone daily (for asthma) for ≥ 3 months
- Previous admission to intensive care for asthma

5.3. Use search tools to support proactive case finding

A wide selection of case-finding and population health management tools are available to support identification of uncontrolled asthma patients. The AAC has developed some useful resources around this to support local asthma leads. The choice of appropriate tools will be in line with local needs and pathways and will be at the discretion of local leads.

Acronyms:

ED - Emergency department
ACT - Asthma control test
ACQ - Asthma control questionnaire
SABA - Short-acting beta-agonist
SAC - severe asthma centre

OCS - Oral corticosteroid
ICS - Inhaled corticosteroid
LABA - Long-acting beta-agonist
LTRA - Leukotriene receptor antagonist

LAMA - Long-acting muscarinic antagonists
COPD - Chronic obstructive pulmonary disease
MTD - Multi-disciplinary team
GP - General practitioner

6. Elements of Optimisation

6.1. Elements of asthma optimisation in primary care to include:

- Review patient notes to confirm diagnosis (do not necessarily need to repeat all investigations)
- Review and optimize inhaler technique: can also support patients by directing to online videos [here](#) and [here](#)
- Ensure the patient has a written or digital personalised self-management plan
- Adherence: review medicine possession ratio for ICS containing prescriptions
- Step up treatment to ICS/LABA +/- LTRA + LAMA ([as per local and national guidance](#))
- Consider environmental agenda and [shared decision making](#)
- Review history to consider asthma mimics and comorbidities such as allergic rhinitis, COPD, anxiety symptoms and breathing pattern disorders (for example hyperventilation)
- Lifestyle
- Smoking cessation
- Weight management/encourage physical activity
- Consider social and psychological aspects that might be impacting on asthma control and refer as appropriate
- Maintenance OCS should no longer be initiated routinely as part of the asthma treatment pathway given the increased burden of comorbidities associated with these drugs

6.2. An aide memoire designed for clinicians undertaking asthma reviews to help review the indicators for referral to secondary care: [HASTE checklist](#)

High intensity treatment: is the patient already at the high-end of the treatment escalator

Adherence: is the patient taking their medication at the correct dose and frequency

Severe exacerbations: has the patient had ≥ 2 courses of oral corticosteroids or been hospitalized due to asthma?

Technique: is the patient's inhaler technique correct

Exclude other conditions: manage conditions that mimic or exacerbate asthma

6.3. If patient remains uncontrolled following optimisation, patient should be referred to secondary care within 6 months of initial asthma consultation

7. Integrated care

7.1. Consider local/community/PCN based respiratory MDT meeting:

- Local health care systems should consider personalised model that support local set up and needs
- Two-way discussion with shared decision making
- Members include Respiratory Consultant, specialist nurse, Practice Nurse +/- GP, District nurse, pharmacist

7.2. Aims:

- Diagnostic clarification
- Complex patients' discussions
- Identify patients with potential severe asthma earlier and to 'pull' into the asthma service prior to hospitalisation or formal referral

8. Local recommendations

8.1. Asthma champion:

- A local asthma champion should be considered to provide leadership around improving asthma care
- Local champion roles will likely differ but may include support around: education, case-finding approaches, adherence and inhaler technique checks, asthma action plans and referrals

8.2. Local/ Community Diagnostic Hubs:

- Involve and integrate into local services for diagnostic and management options
- Access to quality assured diagnostic tests

9. Patients with severe asthma

Ensure SNOMED code for severe asthma is applied (once severe asthma diagnosed in SAC)

Consensus Overviews: Secondary care

10. Referral into Secondary Care

Patients with uncontrolled asthma should be seen by a respiratory specialist within 18 weeks of the referral.

Each secondary care centre should have a nominated asthma lead and a dedicated asthma clinic.

11. Integrated care

Secondary care team should consider offering community Respiratory MDTs to include discussion of patients with asthma.

Support patient diagnosis through community diagnostic centres

Specialist support in primary care

Two-way discussion with shared decision making

Identify potential biologics patients earlier and to ‘pull’ into the asthma service

12. Roles and Responsibilities

12.1 All patients referred to a secondary care with a pre-existing diagnosis of asthma should be assessed to:

- Objectively confirm or reject the diagnosis of asthma
- Phenotype according to biomarkers
- Assess adherence and address suboptimal adherence
- Assess and optimise inhaler technique
- Ensure appropriate level of asthma treatment in accordance with guidelines
- Assess and address relevant comorbidities including psychosocial factors
- Assess oral corticosteroid usage
- Support smoking cessation
- Weight management and physical activity

12.2 All asthma teams to be familiar with NICE indications for biologic prescribing

12.3 Referral to SAC

- Review biomarkers in patients who have had ≥ 3 exacerbations and consider referral to SAC
- All patients on maintenance oral steroids

12.4 Investigations to consider prior to referral to SAC/ discussion at SAC MDT:

- Full lung function testing
- Objective measure of control e.g. Asthma Control Questionnaire
- HRCT thorax (if indicated)
- Measurement of exhaled nitric oxide
- Peripheral blood eosinophil count
- IgE with specifics to common aeroallergens

13. Service Structure

- Each secondary care centre should have a nominated asthma lead and a dedicated asthma clinic.
- All referring centres will be categorised into one of the follow Tiers based on current multidisciplinary workforce and experience.
- Allocation will be made by the local SAC following discussion with the centre.

13.1. Tier 1

No existing asthma clinic or lead. Minimal engagement with SAC network. Will refer all patients to the SAC

Aim: SACs to encourage sites to have an asthma lead and support plans to develop local services. Referral to SAC should be in line with SAC asthma referral protocols

13.3. Tier 2

Has a designated Asthma lead and currently engaged with SAC network with experience of monitoring biologics

Aim: Spokes to accept patients back for continuation of treatment and monitoring following a positive trial at the SAC. Encouraged to engage in SAC MDT

13.5. Tier 3

A designated asthma lead with job planned time for this role, highly engaged in the SAC network with the experience or capability to initiate biologics.

Ability to conduct local asthma MDTs. Access to physiotherapy, SLT and psychology services

Aim: Local initiation and monitoring of biologics after approval at multi-disciplinary meeting with SAC. Patient does not need to be physically seen at the SAC

Acronyms:

SAC - Severe asthma centre

MDT - multi-disciplinary team

HRCT - High-resolution computed tomography

IgE - Immunoglobulin E

SLT - Speech language therapy

Consensus Overviews: Severe asthma centre

14. Roles and Responsibilities

The Severe Asthma Toolkit details biologic choice and assessment of response, MDT processes, adherence assessment and the severe asthma registry

15. MDT Meetings with spoke sites

- SAC to offer minimum of monthly virtual MDT meetings to network tier sites
- Clinicians at tier hospitals able to discuss new or existing patients with severe or complex asthma, and utilize MDT expertise
- Streamline subsequent review at SAC with relevant MDT input
- Opportunity to discuss collaborative asthma research projects

16. Biologic approval and initiation

- Biologic approval as per NICE criteria
- Biologic to be initiated within 4 weeks of MDT approval
- Consider using a validated remote monitoring solution to support monitoring
- Move appropriate patients to home administration of biologic as soon as clinically and practically possible (within 6 months)

17. Monitoring of patients on biologics

17.1. Not on maintenance OCS

- Review 3 to 6 monthly in first year

17.2. On maintenance OCS

- Regular reviews at 4-8 weekly intervals to:
- Guide OCS wean
- Understand any factors contributing to failure to wean
- Assess adrenal function (reviews can be virtual or face to face depending on clinical context)

17.3. Assess response to biologic at 6 months

Indicators of suboptimal response include:

- Minimal symptom improvement (<0.5 improvement in ACQ)
- Failure to significantly reduce mOCS dose (e.g. <50% reduction)
- No significant reduction in exacerbation frequency
- Patient expectations of improvement are not met

Assessment of suboptimal response to include:

- Medication adherence, spirometry, T2 biomarkers, evidence of chronic airway infection
- Consider: Additional imaging (+/- bronchoscopy) if indicated, assessment of comorbidities, sputum induction if available

17.4 Decisions around ongoing management of patients will be determined through SAC MDT

18. Tier-SAC interaction

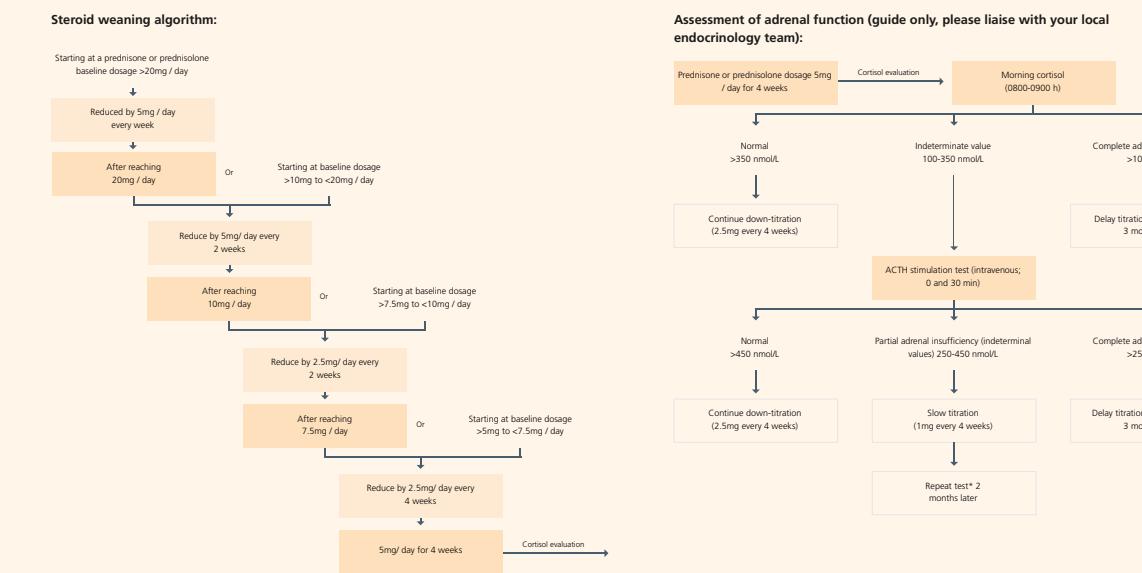
Criteria for discussion with SAC:

- Suboptimal response at 6 months
- >1 severe exacerbation since initiation of biologic or in preceding 12 months
- Annually to review response to biologic and continued use

Ongoing steroid-related toxicity management (e.g. bone mineral clinic) to take place at tier hospitals

19. Steroid weaning (after biologic initiation)

Steroid weaning to begin shortly after biologic initiation- after 1st or 2nd dose
Suggested steroid weaning plan:



Involve local endocrinology team when assessing adrenal function

20. Long-term follow up of patients

- Review 6 monthly by appropriate member of asthma MDT
- Face-to-face review recommended if >1 exacerbation on biologic treatment during the year
- At 12+ months, repatriate 'super-responder' (no OCS for asthma in last 12 months and low symptom score) to spoke hospital
- In general, patients with ongoing OCS requirement to remain under SAC

Acronyms:

MDT - Multi-disciplinary team

SAC - Severe asthma centre

OCS - Oral corticosteroid

mOCS - Maintenance oral corticosteroid

ACQ - Asthma control questionnaire

T2 - Type 2

ACTH - Adrenocorticotropic hormone