

**PCRS briefing paper**

**BTS/SIGN British Asthma Guideline – consultation on latest update Jan 2019**

Background

The BTS/SIGN asthma guideline is a well-established, comprehensive and respected guideline, which first appeared in 2003, and has undergone regular updates. The guideline methodology has been reviewed by NICE and is accredited as a quality guideline.

The latest update was developed during 2018, and the key changes presented at the BTS winter meeting in 2018. A consultation was undertaken between December 2018 and January 2019, in which PCRS took part. The content of this briefing paper is based on the content of our consultation response to BTS/SIGN in January 2019.

BTS/SIGN are expecting to publish a final 2019 update in the summer.

(NICE also published an asthma guideline in December 2017. However this briefing paper refers almost exclusively to BTS/SIGN guideline except where there is a discrepancy between the two guidelines and we indicate that we support NICE guidance on specific issues.)

Outline of content of BTS/SIGN guideline update

BTS/SIGN are always selective about which sections and chapters of the guideline are reviewed at any point in time, according to changes in the evidence. Due to the pace of change in pharmacological developments, the chapter on pharmacological management is updated most frequently. The key areas for update in 2019 include:

* Diagnosis, monitoring, supported self management, non-pharmacological interventions, pharmacological management, inhaler devices

PCRS response/position:

1. We welcome this further update of the long established, comprehensive and highly respected BTS/SIGN guideline for asthma.
2. Due to the potential for confusion from having two national guidelines in the UK, we are hopeful that any future UK guideline for asthma will combine the best of BTS/SIGN and NICE methodologies into a single consensus. For as long as there are two guidelines, we believe it would be helpful if the guidelines developers provided some commentary on differences between the two, which to date they have not.
3. There are a number of issues where recommendations at a government policy level might be made , for example, in respect of smoking cessation services (funding currently threatened) or air pollution . The guideline does not contain any discussion of health inequalities which are important in asthma as in other areas. Action at national level would strengthen the environment within which respiratory care takes place.

Diagnosis

1. We support the use of objective tests in asthma diagnosis, within the context of a structured clinical assessment, involving examination, full family history, and review of patient’s clinical records e.g.
2. Greater emphasis should be placed on clinical and physiological re-evaluation over time, which is key to accurate diagnosis - and to the detection of misdiagnosis. Making an accurate diagnosis may take time and may require the comparison of repeated measurements over time.
3. A Peak flow rate (PEFR) monitoring diary is the most immediately available first line objective test and so should be done in all patents old enough to undertake this. Spirometry with reversibility testing is an additional test that can add to the objective evidence that airways obstruction exists and should be performed where available and where this can be done within a reasonable wait time. Anyone with a high probability of asthma from clinical history, exam and PEFR testing should not delay treatment because of no spirometry service or long waits.
4. We agree with the positioning of spirometry for patients with an intermediate probability of asthma after initial assessment. However, performing and interpreting spirometry is difficult in children, requires significant training and is frequently normal in primary care populations with suspected asthma, so should not be mandatory for asthma diagnosis. (In the NICE field testing pilot study, 70% of those eventually diagnosed with asthma had normal spirometry.) We support the use of lower limit of normal for FEV1/FVC ratio (instead of the fixed ratio of 70%, which may underdiagnose in younger people and overdiagnose obstruction in adults).
5. We agree with the BTS/SIGN positioning of FeNO in diagnosis where there is an intermediate probability of asthma – that it can be useful to establish whether there is eosinophilic inflammation, and provides supporting, but not conclusive, evidence for an asthma diagnosis. A positive test increases the probability of asthma but a negative test does not exclude asthma.

Monitoring

1. We support the inclusion of a section on predicting and assessing future risk. We believe that smoking is responsible for more than a ‘slight increase in risk’. We would expect high SABA use to be mentioned as a risk factor for future attacks under ‘moderately increased risk’ – in adults as well as children.
2. Performing and interpreting spirometry in children is an issue, as the ECCS reference values are not representative of children or the population in general compared to GLI which hasn’t been adopted in the UK. Spirometry in children needs careful interpretation and certainly to be considered in line with the history.
3. We agree with the stance BTS/SIGN takes on FeNO in monitoring asthma, that the evidence does not support its routine use in adults or children.

Supported self management

1. We welcome the recommendation to quadruple the dose of inhaled steroid to abort an asthma attack in recognition of the growing evidence that this intervention can be helpful. However we believe non-specialist clinicians may be cautious about this level of steroid use and suggest that BTS/SIGN frame this in context of oral steroid doses as reassurance.
2. We agree that healthcare staff need to be trained in supporting patients in self managing, and that there are healthcare professionals managing asthma who don’t have such training, either in conducting regular reviews or in supporting self management specifically.

Non-pharmacological interventions

1. The guideline should state that that VBA (very brief advice) to trigger a quit attempt from healthcare professionals in all settings and pharmacotherapy-supported behavioural interventions to treat tobacco dependency is a highly cost effective health care intervention relevant to patients with an asthma treatment plan. Local authority funding for smoking cessation services has been reduced in many areas and BTS/SIGN has traditionally been fairly low key about treating tobacco dependency and we believe this needs to be rectified with more of a focus placed on the responsibility of the asthma health professional to deliver this essential component even when services are not available.

Pharmacological management

1. We support the prescribing of inhalers by brand name to ensure that the patient receives the inhaler the prescriber intended and which the patient is familiar with.
2. We continue to find BTS/SIGN cautious in its recommendations about an appropriate number of SABA inhalers a year. Given the recommended frequency of SABA use and the concerns at excessive SABA use as a marker of poor control - should this threshold not be lower than 12 a year? Six inhalers per year rather than twelve? NRAD identified 12 per year as a marker of those who had such severe asthma that they died.
3. We are currently considering our stance on MART regimes.
4. PCRS supports the value based approach which NICE takes to deciding on the first line add-on to ICS. NICE recommends the use of LTRA in this context, since the marginal superiority of LABA is outweighed by its greater cost. We therefore advise following NICE’s recommendation to use LTRA as first line add on, rather than BTS/SIGN’s recommendation of LABA. However the decision for individual patients should be made between clinician and patient, since both are options.

Inhaler devices

1. We believe that the important role of spacers in helping to deliver medication to the lungs when used with an MDI has been underplayed in guidelines and needs strengthening. Spacers can help to overcome the difficulties associated with inhaler technique with MDIs.
2. We support the practice of inhaler choice being down to the clinician and individual patient.
3. The current draft BTS/SIGN guideline has introduced a statement about the global warming potential (GWP) of fluorinated gas propellants (HFCs) which are contained in MDIs. PCRS supports measures to reduce potential harm to the environment from inhaler use. However we warn against any ‘blanket switching’ from MDIs to DPIs, and encourage any decisions about inhaler choice to be made on an individual basis between clinicians and patients. We would also emphasise the importance of MDIs continuing to be available, because of the important role they play in preventing exacerbations, when used with spacers.
4. We would prefer to see a broader statement about how to reduce the overall GWP contribution of asthma treatments. This would cover a variety of issues : better education and adherence with preventer use in asthma, routine spacer use if using MDIs, minimising propellant per dose where the change is acceptable to patients, recycling schemes for inhaler devices, switching from pMDI to DPI where the change is clinically appropriate, safe and acceptable. A multifaceted approach of this kind is more likely to be effective in reducing propellant use. It should also be mentioned that alternative low GWP propellants for MDIs are under development. (Parliamentary Environmental Audit committee. UK progress on reducing F-gas emissions. 2018)

References, links and quotes:

British Guideline on the management of asthma – SIGN /BTS DRAFT December 2018 accessed 18.3.19 <https://www.sign.ac.uk/assets/asthma-consultation-draft.pdf>

Asthma Guidelines in Practice - A PCRS Consensus – PCRU article in Spring 2018 edition (based on BTS/SIGN guideline Sept 2016). accessed 18.3.19 <https://www.pcrs-uk.org/sites/pcrs-uk.org/files/Asthma%20GuidlinesFINAL_AOP.pdf>

News item on publication of PCRS consensus article. accessed 18.3.19 <https://www.pcrs-uk.org/news/pcrs-publishes-consensus-statement-clarify-confusion-over-asthma-care-guidelines>

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