Consultation on the draft SIGN guideline on the management of asthma

Q1. Title

Dr

Q2. First name

Deepak

Q3. Last name

Dwarakanath

Q4. Job title

Vice President

Q5. Place of work

Royal College of Physicians of Edinburgh

Q6. City

Edinburgh

Q7. Email

s.collier@rcpe.ac.uk

Q8. Relationship to SIGN

Open consultation

Q9. REMUNERATION FROM EMPLOYMENTEmployment held which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q10. REMUNERATION FROM SELF EMPLOYMENTSelf employment held which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q11. REMUNERATION AS HOLDER OF PAID OFFICEOffice held which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q12. REMUNERATION AS A DIRECTOR OF AN UNDERTAKINGDirectorship held which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q13. REMUNERATION AS A PARTNER IN A FIRMPartnership held which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q14. SHARES AND SECURITIESInterests in shares and securities in commercial healthcare companies, organisations and undertakings(value need not be disclosed)

No

Q15. REMUNERATION FROM CONSULTANCY OR OTHER FEE PAID WORKConsultancy or other fee paid work commissioned by, or gifts from, commercial healthcare companies,organisations and undertakings which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q16. Non-financial interests which may be significant to, or relevant to, or bear upon the work of sign

No

Q17. Non-personal support from commercial healthcare companies, organisations or undertakings which may be significant to, or relevant to, or bear upon the work of SIGN

No

Q26. 2.3 NON-PHARMACOLOGICAL MANAGEMENT

Agree.

Q27. 2.4 PHARMACOLOGICAL MANAGEMENT

Agree.

Q28. 2.5 INHALER DEVICES

We would like to see the evidence base for this statement as the prescribing of many branded inhalers

Q28. 2.5 INHALER DEVICES

can be equally challenging. However, there have been cheap imports of variable quality and perhaps this is what this refers to.

Q29. 2.6.1 ADULTS

Agree, but it is important to stress that "controlled" does not imply that if the PaC02 is high this is in an indication to lower the Fi02 i.e. avoid any confusion with the management of COPD.

Q34. 2.9 OCCUPATIONAL ASTHMA

Agree.

3.1.1 DEFINITION

Agree.

Q35. 3.1.2 TESTS INFLUENCE THE PROBABILTY OF ASTHMA BUT DO NOT PROVE A DIAGNOSIS

Agree.

Q36. 3.1.3 ASTHMA STATUS AND THE OUTCOME OF DIAGNOSTIC TESTS FOR ASTHMA VARY OVER TIME

Agree, and this is very important.

Q37. 3.2 PREDICTIVE VALUE OF INDIVIDUAL SYMPTOMS, SIGNS AND DIAGNOSTIC TESTS

Agree.

Q38. 3.2.1 SYMPTOMS AND SIGNS

Agree.

Q39. 3.2.2 SPIROMETRY AND BRONCHODILATOR REVERSIBILITY

Agree, but these emphasise the preceding comments that the diagnosis of asthma should not be based on isolated symptoms or isolated lung function tests. Many GPs and Practice nurses may find this section confusing.

Q40. 3.2.3 TESTS OF VARIABILITY IN LUNG FUNCTION

Agree. We think this is important and that in adults these tests may be under-used.

Q41. 3.2.4 TESTS TO DETECT EOSINOPHILIC INFLAMMATION OR ATOPY

Agree. We would suggest the wording emphasising potential confounders could be stronger.

Section D - (FeNO measurements) - However, a negative test does not exclude the diagnosis of asthma.

Q42. 3.3 PRACTICAL APPROACH TO DIAGNOSIS

This section is over-complicated. It should aim to emphasise that as there is no gold standard, that asthma is a variable condition and that its diagnosis can be challenging. Failure to establish the correct diagnosis is common and common pitfalls are...

Q43. 3.3.1 INITIAL STRUCTURED CLINICAL ASSESSMENT

An important message that is missing here is a presentation with repeated 'lower respiratory tract infections'.

Q44. 3.3.2 HIGH PROBABILITY OF ASTHMA BASED ON INITIAL STRUCTURED CLINICAL ASSESSMENT

Agree.

Q45. 3.3.3 LOW PROBABILITY OF ASTHMA BASED ON INITIAL STRUCTURED CLINICAL ASSESSMENT

Agree.

Pertussis ought to be considered even in the absence of coughing leading to vomiting. It's sometimes referred too as the cough of 100 days and adult-onset Pertussis has recently been more commonly seen.

Q46. 3.3.4 INTERMEDIATE PROBABILITY OF ASTHMA BASED ON INITIAL STRUCTURED CLINICAL ASSESSMENT

Agree with this table.

Q47. 3.3.5 INDICATIONS FOR REFERRAL

Agree.

Q48. 3.4 ORGANISATION OF DIAGNOSTIC SERVICES

Agree.

Q66. 5.4.1 ADHERENCE TO MONITORING AND TREATMENT

Agree. This is a significant issue and it is correct to emphasise this.

Q66. 5.4.1 ADHERENCE TO MONITORING AND TREATMENT

Re the Necessity-Concerns Framework - This appears to be common sense. However, if referred to, it would be helpful to provide some guidance as to the commonly recognised 'disadvantages' contributing to non-adherence and suggested strategies for managing this.

Q67. 5.4.2 ASSESSING MEDICATION ADHERENCE

This is helpful. However, measurement of the serum eosinophil level has been omitted; this is easily available and usually suppressed by effective treatment.

Section D is very helpful.

Q80. 6.1.8 WEIGHT REDUCTION IN OVERWEIGHT AND OBESE PATIENTS

RCPE would strongly agree with the promotion of weight reduction. It is also important to obtain good control to facilitate exercise to promote weight loss, and to avoid Prednisolone rescue therapy which may counteract weight loss.

Q103. 7.1 INTERMITTENT RELIEVER THERAPY

Agree, although there is an argument for early introduction of inhaled steroid therapy in what is an inflammatory condition in which it is well known that patients under-estimate their symptoms.

Q111. 7.2.6 SMOKING AND INHALED CORTICOSTEROIDS

Agree. This is an important message.

Q115. 7.3.2 INHALED LONG-ACTING β2 AGONIST

Agree.

Q118. 7.4 ADDITIONAL ADD-ON THERAPIES

Agree.

Q119. 7.4.1 INCREASED DOSE OF ICS

Agree.

Q120. 7.4.2 LEUKOTRIENE RECEPTOR ANTAGONISTS

Agree.

Q121. 7.4.3 LONG-ACTING MUSCARINIC ANTAGONISTS

Agree.

Q122. 7.4.4 OTHER APPROACHES

This section could perhaps also draw attention to unpredictable metabolism in smokers and the potential for some antibiotics to alter therapeutic levels.

Q123. 7.5 HIGH DOSE THERAPIES

Agree.

Q128. 7.7.1 ANTI-IgE MONOCLONAL ANTIBODY

Agree.

Q146. 8.4 PRESCRIBING DEVICES

As set out earlier in the document, prescribing branded inhalers can be equally fraught with problems.

Q161. 9.3.1 OXYGEN

Agree. As mentioned earlier when using the term controlled oxygen, it is important to be clear that this is not completely synonymous with COPD and a high PaC02 is not necessarily an indication to reduce oxygen concentration.

Q162. 9.3.2 ß2 AGONIST BRONCHODILATORS

These are seldom used in UK, but it is acceptable to include them in the guideline.

This is not controversial, although many patients when acutely unwell cannot manage their inhalers.

Q163. 9.3.3 STEROID THERAPY

Agree. This is an important message.

Q172. 9.3.12 CRITICAL CARE SETTINGS

We would endorse this.

The use of Ketamine can be associated with significant psychological side-effects, so the downside of therapy can easily out-weight the unproven benefit. This section could suggest this treatment should be avoided outside of the context of further RCTs.

Q173. 9.3.13 NON-INVASIVE VENTILATION

Yes, usually airway pressures in asthma is too high. NIV is likely to be ineffective and distressing to a patient already in a distressed and anxious state.

Q202. 10.2.1 POOR ADHERENCE

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Agree. As mentioned above this is very important.