COPD Exacerbation Rescue Medication Pack - Guidance for Prescribers
(Use in conjunction with Nottinghamshire COPD guidelines)

Patient held emergency supply packs of exacerbation rescue medication (antibiotics and/or steroids) are recommended for patients who are **able and willing** to self-manage and have a COPD self-management plan. Patients experience exacerbations differently, but a given patient is likely to have the same symptoms each time.

Criteria for considering emergency supply packs (exacerbation rescue packs):

- Any patient with a confirmed diagnosis of COPD who has had 2 or more exacerbations or has visited A&E/been admitted to hospital with an exacerbation of COPD.

Advice for patients:

- When to start taking rescue medication:
  - If sputum has increased/changed in colour/thickness → **start antibiotics**
  - If significant and persistent worsening of breathlessness/usual symptoms which do not respond to increasing SABA → **start steroids**
- Patients may need antibiotics **OR** steroids, but **not necessarily both**.
- Not all patients will exhibit these typical symptoms of exacerbation.
- Patients must contact their GP surgery or COPD specialist nurse if starting their exacerbation rescue packs.
- Patients can request a further supply once the exacerbation rescue packs have been used.
- A sputum sample will be requested from patients with frequent exacerbations or prescription requests.
- The indication will be added to the dosing instructions as a reminder e.g. 'To be taken in the event of a COPD exacerbation'.
- Patients should check expiry dates on packs if infrequently used.

Treatment:

Antibiotic[1]	Dosage	Duration
First line options:		
Doxycycline[2] **OR**	**Adult:** 200mg first day then 100mg once daily.	5 days
Amoxicillin	**Adult:** 500mg three times a day.	5 days
In penicillin allergy and/or doxycycline contraindicated:		
Clarithromycin[3]	**Adult:** 500mg twice a day.	5 days
Second line: Use alternative first line (from a different class). **Alternative choice** (if person at high risk of treatment failure, guided by susceptibilities when possible): See Nottinghamshire APC Antimicrobial Guidelines - Acute Exacerbation of COPD for guidance on alternative antibiotic choices but note that these should be prescribed on an individual case by case basis and not issued repeatedly without review. Note some patients may require longer courses, particularly in bronchiectasis.		
Steroid[1]	**Dosage**	**Duration**
Prednisolone (Use plain prednisolone as more cost effective and no evidence of any benefit from enteric coated.)	30mg (6x5mg) once daily	5 days
If symptoms have not resolved, the patient should be reviewed prior to prescribing further prednisolone. Consider the need to supply Steroid Treatment card and/or Steroid Emergency Card		

[1]See BNF and BNFC for appropriate use and dosing in specific populations, e.g., hepatic, or renal impairment, pregnancy, and breastfeeding.
[2]Doxycycline is not suitable for pregnant women.
[3]Withhold statins whilst on clarithromycin course.

Update ratified by Medicines Optimisation Steering Group 23/03/2023

Follow up and re-issue of exacerbation rescue packs (practice advice):

- **The GP practice should have a process in place for supply, monitoring and review of exacerbation rescue medication.** Reviews should occur regularly and at least at every annual review. This should be reflected in the GP practice prescribing policy. See Repeat Prescribing Guide for GP Practices for further information.
- A request for a supply of an exacerbation rescue pack should prompt a review/discussion with the patient if the practice wasn't notified of the previous course being taken.
- **A sputum sample must be requested from patients with frequent exacerbations or prescription requests.**
- Exacerbation rescue packs are **not recommended on repeat prescription**, unless there is a robust practice policy in place to ensure that packs are not issued without review.

Read codes to use on clinical systems:

- Advanced supply of antibiotic medication – XaR21
- Advanced supply of steroid medication – XaR16

Things to consider if patient is exacerbating frequently (2 or more exacerbations in a 12-month period) or if patient is not responding well to treatment of exacerbations:

- Are exacerbation rescue packs being used appropriately and **is self-management still appropriate?**
- **Are they true exacerbations?**
- Re-assess for co-morbidity, treatment adherence and inhaler technique. Reiterate the need to reduce cigarette usage in smokers. If the patient is a smoker, they should be referred to the cessation service.
- Consider bronchiectasis and check sputum for unusual organisms (including AFB).
- Consider chest X-Ray, bloods tests and investigations to exclude malignancy.
- Review regular medication and **optimise inhaler therapy** (See Nottinghamshire COPD Guidelines). Any change to inhaler regime, should be started at a period of clinical stability i.e., at least 4 weeks after exacerbation and response should be monitored. Document reason for change in medication.
- **Consider fracture risk and bone densitometry:** ≥3 courses of oral prednisolone in 12 months is a trigger to consider the need for bone protection. However, note that some patients who have fewer than 3 courses may also be at risk if other risk factors are present.
- Consider whether a **one-off** longer course of prednisolone is required (e.g., 10-14 days) and whether +/- weaning down to 0mg, rather than stopping abruptly, would be beneficial.
- Is the patient able to use airway clearance techniques?
- Consider referral to secondary care for a COPD specialist review.

Other:

- Primary care support tool - How to manage and review adults on long term and repeated antibiotics for the prevention and treatment of COPD exacerbations. TARGET How to ……?

References:

Antibiotics: NICE NG 114 COPD (acute exacerbations) December 2018
Steroids: NICE NG115 COPD in over 16s: diagnosis and management July 19