Asthma: diagnosis, monitoring and chronic asthma management

Consultation on draft guideline – deadline for comments 5pm on 30/07/24 **email:** asthmachronicmanagement@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. The updated recommendations in this guideline will require the NICE indicator on asthma diagnosis (NM166), currently included in NHS England's Quality and Outcomes Framework (QOF AST011), to be amended. The current wording for NICE indicator NM166 is: *The percentage of patients with asthma on the register from (start date) with a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 3 months after diagnosis*. Please indicate whether you would prefer an updated indicator to focus on the initial diagnostic test (option A) or any objective test (option B) around the time of diagnosis, and why: A. The percentage of patients with asthma on the register from (start date) with a record of fractional exhaled nitric oxide (FeNO) (adults and children) or blood eosinophil count (adults) or spirometry with bronchodilator reversibility (children), between 3 months before or 3 months after diagnosis. B. The percentage of patients with asthma on the register from (start date) with a record of an objective test (eosinophil count, fractional exhaled nitric oxide (FeNO), spirometry, peak flow with bronchodilator reversibility, bronchial responsiveness (in adults), skin prick test or blood IgE level (in children)) between 3 months before or 3 months after diagnosis.

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	See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Royal College of General Practitioners
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	No disclosures
Confidential comments (Do any of your comments contain confidential information?)	No
Name of person completing form	Michael Mulholland/ Adrian Hayter/ Anika Mandla

Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number** **'General'** for comments on whole document	**Line number** **'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
1	Guideline	4	15	We agree. This is important for primary care communication, continuity and the ability to review diagnoses including when tests are inappropriate or unavailable at initial contact.
2	Guideline	5	2	We agree, in primary care it is common for people with mild or dormant asthma to have no active signs.

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3	Guideline	5	22	This is clearly worded. However, interpretation of eosinophilia is relatively new to some GPs so it may be useful to have additional information (in the guideline rationale?) about other causes of eosinophilia such as medicines, parasitic diseases, malignancy.
4	Guideline	5	26	We question why peak flow variability/ reversibility, a very accessible and moderately accurate test is not mentioned at all. 1) Peak flow reversibility has already been included as an option- 1.1.5 but then omitted it here; 2) Pragmatism appears to have been ignored: for a small theoretical gain in accuracy, a highly accessible tool has been excluded. This is a significant hurdle for good primary care management. We believe it is important to include peak flow in the guideline.
5	Guideline	5	26	We believe spirometry with reversibility is not a good test for primary care patients. Unless it is immediately available it has poor sensitivity in a primary care setting. This criticism fits the statement in 1.1.4 where it is stated that examination may be normal and in these circumstances most people with also have little or no reversibility despite a clear history of asthma. We recommend reviewing this statement with application to real world primary care evidence.
6	Guideline	6	3	The wording of this recommendation is unclear about what is measured “bronchial hyper-responsiveness”, the glossary doesn’t help – We question if these are PFR readings?
7	Guideline	6	4	We would like to make the same comments as for the adult section: We question why peak flow variability/ reversibility, a very accessible and moderately accurate test is not mentioned at all. 1) Peak flow reversibility has already been included as an option- 1.1.5 but then omitted it here; 2) Pragmatism appears to have been ignored: for a small theoretical gain in accuracy, a highly accessible tool has been excluded. This is a significant hurdle for good primary care management. We believe it is important to include peak flow in the guideline. We believe spirometry with reversibility is not a good test for primary care patients. Unless it is immediately available it has poor sensitivity in a primary care setting. This criticism fits the statement in 1.1.4 where it is stated that examination may be normal and in these circumstances most people with also have little or no reversibility despite a clear history of asthma. We recommend reviewing this statement with application to real world primary care evidence.
8	Guideline	7	9	In contrast to our comments on older children and adults, this is a very pragmatic and helpful statement. Using clinical judgement, trials of treatment, and reconsidering the diagnosis on a regular basis is a very common-sense approach.
9	Guideline	8	16	We Would welcome additional information here (FeNO monitoring at review 1.5.4) about interpretation & action.

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10	Guideline	8	24	We agree that regular peak flow monitoring has limited benefit but: 1) it provides a baseline which can be used to help primary care decision-making in and exacerbation of or acute asthma. Intermittent monitoring can also help to document peak flow reduction in patients who might be developing COPD or might need further investigation. It's easy to do and its absence deprives the GP of a useful clinical insight.
11	Guideline	10	1	Use of e-cigs – The wording for recording the use of e-cigs could be strengthened in line with MHRA. https://www.gov.uk/drug-safety-update/e-cigarette-use-or-vaping-reminder-to-remain-vigilant-for-suspected-adverse-reactions-and-safety-concerns-and-report-them-to-the-yellow-card-scheme (EMIS coding currently allows recording of e-cigs but not the level of detail advised by the alert)
12	Guideline	11	8	We believe, it is not realistic to observe inhaler technique at every consultation
13	Guideline	12	1	We understand the wish to move to 'MART' therapy. However, we question if there is any good evidence on the risks of steroid overuse and the development of temporary adrenal hypofunction. As this can be a factor in asthma deaths with people given repeat steroids and suffering recurrences on cessation, this therapy may need careful monitoring and this isn't included in the guideline.
14	Guideline	13	8	What patient characteristics /subgroups/phenotypes who are most likely to benefit from LTRA? We wonder if it would it be useful to include further information.
15	Guideline	13	16	*Give the LTRA for a minimum trial period of 3 months (unless there are side-effects) and then stop it if it 12 is ineffective. [2024] instead, w*e recommend making the review more - E.g. Review at 3 months, assess for benefits and adverse effects. Montelukast has had a recent updated MHRA alert/reminder. Additionally, we know that once medicines are put onto repeat it is difficult to evaluate benefits, difficult to stop, and adds to concerns of problematic polypharmacy and risk of medicines interactions https://www.gov.uk/drug-safety-update/montelukast-reminder-of-the-risk-of-neuropsychiatric-reactions .
16	Guideline	13	18	We agree, but it is important to note individual differences - A burly male prop forward will need and tolerate higher doses than a frail underweight elderly lady. Whilst it may be argued that this is just a guideline and that individual judgement is important, NICE guidance is often not seen like that by users or by those scrutinising the users. Extra qualitative recommendations are needed here.
17	Guideline	13	general	"Asthma that is not controlled" We could give clear advice to patients about poor control of asthma such as salbutamol use 2-3/week. Is there an equivalent for MART in this guideline?

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18	Guideline	19	27	It is important to recognise BNF advice for montelukast pregnancy. Similarly, Rec 1.12.5 suggests use BNF wording which is clearer
19	Guideline	21	19	We recommend rephrasing this in order for it to be realistic
20	Guideline	22	2	We believe, the first bullet point describing personalised action plans should include: Plans should be available in a form tailored and individualised to the person. Use of inhalers should be regularly reinforced by repeated instruction when needed. Education of caregivers and family members should be considered depending on the assessed capacity of the person and shared decision making has to be Triadic when necessary. Davis S et al 2016. Asthma in intellectual disability: are we managing our patients appropriately? Breathe 12(4)
21	Guideline	23	1	The accompanying quality assessment accepts that people with LD are at increased risk but 1.15.1 makes no specific mention of their needs in spite of the clear evidence that 28% - 50% of preventable premature deaths in patients with LD are due to respiratory causes, 7 times more frequent than for the general population, Glover G and Ayub M How people with Learning Disabilities Die 2010 Improving Health and Lives: Learning Disabilities Observatory and people with LD have twice the incidence of asthma than the general population Gale L et al 2009 Asthma, smoking and BMI in adults with intellectual disabilities: a community based survey J Int Dis Res 53(9) 787-797 1.15.1 should include a 4th bullet point stating • the person has learning disability If the text of the guidelines remains unchanged other than this amendment, then there should be a link to the equality impact assessment at the first bullet point of 1.15.1.
22	Guideline	23	5	This is a useful recommendation but 'Actively identify people who overuse SABA' is not in itself very helpful. We wonder if it can be linked to established audit /medicines safety criteria?
23	Guideline	23	10	We believe this should include a reference to the Reasonable Adjustment Digital Flag, to be referred to at the times of acute care and mention that access issues due to learning disability should be considered if a patient does not attend or "was not brought", using the appropriate codes which would trigger appropriate action to ensure monitoring arranged by contacting carers or other supportive

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				agencies together with ensuring access is tailored to each patient's needs. Davis S et al 2016. Asthma in intellectual disability: are we managing our patients appropriately? Breathe 12(4)
24	Guideline	General	General	Supportive references: NHS Dec 2023 Health and Care of People with Learning Disabilities. Experimental Statistics, Other reports and statistics reports2022-2023 LeDeR Action from Learning Report 2022 and 2023
25	Guideline	General	General	It is very common for people with asthma in primary care, usually with milder chronic or intermittent disease, to have specific triggers eg exercise, or temporary exposure to allergens. This document provides no guidance on how to manage these situations. For some, regular ICS or MART may be appropriate; for others, particularly those with only occasional symptoms (and I count myself amongst these) surely a quick restorative puff of salbutamol makes more sense.

Insert extra rows as needed

Data protection
The information you submit on this form will be retained and used by NICE and its advisers for the purpose of developing its guidance and may be passed to other approved third parties. Please do not name or identify any individual patient or refer to their medical condition in your comments as all such data will be deleted or redacted. The information may appear on the NICE website in due course in which case all personal data will be removed in accordance with NICE policies.

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