INHALER SWITCHING

I would like to think that what I am going to discuss is a thing of the past, as many conversations have been had at many levels over the decades I've been in practice. However, people move, and messages get lost and or ignored. What am I talking about? The title gives it away “inhaler switching” either by letter or instruction for repeat prescription to be changed and wholesale switching happens with patient being ‘notified’ of the change and not discussed with them. Very often we hear ‘the right inhaler is the inhaler a patient uses’, which in my book translates to whatever inhaler the patient is currently stable on is the right one?

Those who are experienced practitioners know wholesale switching destabilises the whole disease population, usually asthmatics as is the case now. We are not dealing with tablets but medical devices with many differences that can contribute to ‘critical errors’ and patient not receiving the correct dose. For e.g. the current drive to switch from Fostair pMDI to Luforbec (Lf), Lf dose counter goes down in 20 increments and stops at 20, so a patient for instance on MART therapy has no idea how many doses they have left should they need to increase or treat and acute attack. As you know many inhalers will keep pumping out propellant long after the drug has run out. This is one example and traveling around the South West I have had a lot of anecdotal evidence from clinicians of the majority of patient having to switch back after destabilisation, admissions to secondary care and ITU admissions. The human cost here is high.

I fully understand the necessity to switch to cheaper alternatives, but this should never be done without discussing with the patient’s clinician and I include pharmacists in this. The caveat being if that patient destabilises as a consequence of a switch, it is that clinicians’ responsibility to see the patient thereafter (I include pharmacists in this). Switching should be undertaken at the annual review or at lease ‘face to face’ discussing why and the alternatives. This process is very advanced in other areas of the South West and it’s the nurses that are picking up the pieces of the patients destabilising. I would advise any nurse who has had a patient return after switching to an ‘equivalent inhaler’ and destabilised or had symptoms such as cough (this is common) to ‘yellow card’ it.

If environmental issues concern you, then you need to understand if an asthmatic has a DPI (SABA) they have to change this every 6/12 (shelf life once opened) so a minimum of 2 inhalers a year (2 lots of plastic) even if their asthma is stable. New inhalers pMdi’s will be on the market in 2025 with equivalent impact as dpi’s, so not long to wait. It takes a long time to stabilise patients and build a rapport and confidence in a clinician/patient relationship. This can be undone so easily, so I would recommend that practises have a discussion about inhaler switching and the best mechanism to do this i.e. those who are new patients or exacerbated and need a change in inhalers. Not all inhalers are equal and equivalent. I am passionate about this as very often in the past, as now I’ve seen the ‘fallout’ and human cost to this practice, so I make no apologies. Lead clinicians please stand by your respiratory nurse specialists.

SPIROMETRY
There is document that might help practices if they are thinking of undertaking spirometry again within their own practice. The link is here and it takes you to a document on Teams Net : https://teamnet.clarity.co.uk/l85025/Topics/View/Details/125c1048-d56c-408e-938e-b01f0095eea9

Kind Regards

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