



EDITORIALS

Conflicting asthma guidelines cause confusion in primary care

A way forward for clinicians while we streamline the guideline process

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Asthma is a common and potentially serious chronic condition that continues to cause avoidable morbidity and mortality.¹ The majority of asthma management takes place in primary care.

Since 1992 asthma guidelines from the British Thoracic Society (BTS), now under the auspices of the Scottish Intercollegiate Guideline Network (SIGN), have been widely accepted and used in the United Kingdom.² With the recent publication of a guideline by the National Institute for Health and Care Excellence (NICE)³ we now have substantially conflicting advice on key issues in asthma diagnosis and management. Differing conclusions have been reached by looking at very similar evidence. Why has this happened and what are primary care professionals to do?

In 2013 it was decided that NICE would produce guidelines for diagnosis and monitoring of asthma, and later for the management of chronic (but not acute) asthma. Reasons included a wish to incorporate cost effectiveness analyses—which the BTS/SIGN guideline does not consider—and concerns about overdiagnosis, overtreatment, and consequent waste of resources.

From the outset concerns were expressed that NICE would either duplicate the advice from BTS/SIGN—at considerable cost—or provide conflicting guidance. What has happened is a bit of both, causing confusion among health professionals and risking worse outcomes for people with asthma.

NICE issued a draft form of the guideline on diagnosis and monitoring for consultation in 2015. It recommended using both spirometry and fractional exhaled nitric oxide (FeNO) testing to confirm a diagnosis of asthma, rejected the concept of trials of treatment as a diagnostic tool, and relegated the low cost, high specificity, and widely available technique of peak flow monitoring to a subsidiary role. It also recommended bronchial challenge testing, which is not widely available, for patients with inconclusive results from spirometry and FeNO tests.

The consultation revealed widespread concern in the respiratory community about the draft recommendations,⁴ which could shift the diagnosis of asthma from primary to secondary care and increase hospital referrals. FeNO testing is expensive and is

currently available in only a few general practices and 64% of hospital services.⁵ Opinion varies over its diagnostic value—a strategy document from the Global Initiative for Asthma (GINA) states that FeNO testing has no useful role.⁶

Spirometry results are normal in most primary care patients with asthma, and there are concerns over the quality of spirometry in this setting. NICE made no allowance for the cost of increased referrals to secondary care for FeNO testing or spirometry. Publication of the guideline was therefore paused, pending a pilot study in primary care, but it has now been published virtually unchanged.

In December 2016 the draft guideline on management of chronic asthma was released for consultation. It largely mirrors recommendations from BTS /SIGN but has one important and controversial difference—the recommendation (on cost effectiveness grounds) of leukotriene receptor antagonists as first choice add-on therapy for patients whose asthma is not well controlled with low dose inhaled corticosteroids. Long acting β agonists (the BTS/SIGN recommendation) are marginally more effective, but the difference is too small, in the analysis by NICE, to justify the additional cost.

What are healthcare professionals to do?

The Primary Care Respiratory Society UK has produced consensus advice on how to deal with conflicting national guidelines.⁷ For diagnosis, it broadly supports the BTS/SIGN approach. It reasserts the prime importance of good clinical method and regular reassessment. It agrees with the need for objective testing and prioritises peak flow monitoring, alongside trials of treatment if necessary, as the initial objective test in primary care. Spirometry and FeNO testing are additional options for patients in whom the diagnosis remains unclear.

Like NICE, the society recommends investigating the feasibility of diagnostic hub services to provide tests not available in primary care.

For treatment, it cautiously accepts the cost-benefit arguments for an initial trial of leukotriene receptor antagonists as add-on treatment to low dose inhaled corticosteroids but emphasises

that there is no need to change the treatment of patients already established on long acting β agonists.

We need a single UK asthma guideline

NICE has a vital role in ensuring the cost effectiveness of health services in England and Wales. But it has taken four years to produce guidance that does not cover the whole of asthma care and which much of the respiratory community finds problematic. The authors of a recent retrospective analysis of data from a population based cohort study advised that NICE's proposed diagnostic algorithm should not be used in children.⁸

The UK needs a single, regularly updated, comprehensive, and evidence based guideline covering both diagnosis and management. It should incorporate health economic analysis of key options where necessary. The logical way forward is for the comprehensive BTS/SIGN guideline to continue, with NICE contributing resources to the task and expertise in cost-benefit analysis.

This would be a new form of cooperation between the two guideline organisations. But people with asthma, and the health professionals who care for them, deserve this cooperation and the best possible use of limited resources for the development and maintenance of asthma guidelines.

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