3A(1b)

Case Report

Select one problem or random case from your normal surgeries for reflection and analysis. This case should illustrate a prescribing issue.

Explain why this case is clinically significant for you.

54 year old man. Longstanding history of low back pain. Permanently off work.

Seen in 1998 by a partner with SOB and wheeze. Was taking propranolol for anxiety episodes. Family history of asthma (son). Treatment given – propranolol was stopped and budesonide turbohaler started. When reviewed at 1 month wheeze had subsided and budesonide turbohaler was added to his repeat scripts.

January 2002. Seen by practice nurse at our new asthma/COPD clinic.

Spirometry performed which showed a restrictive defect. Nurse noted that his inhaler technique was poor and gave help with this. In view of his abnormal spirometry she also advised that he move to higher dose of inhaled budesonide (400mcg – 800mcg).

February 2002. Seen in surgery by myself. Felt his inhaler at the higher dose was not working. I advised changing the inhaler to a "normal" MDI and use this with a volumatic. Patients Rx changed to becotide 200mcg – 4 puffs twice daily.

A review appointment was organised.

What decisions did you take in relation to this case and why?

Due to the start of our asthma/COPD clinic we had spent an evening with the practice nurses on spirometry training. We also learned that turbohalers require significant inspiratory flow if they are to work and many patients are unable to use them.

I made the assumption that this patient had asthma and his control could be optimised by following the BTS guidelines. Hence I thought that the advice he had been given to move from low dose inhaled steroid to higher dose (Step 3) was correct.

At his review appointment the patient reported no improvement in his condition. I was considering moving to Step 4 – addition of a long acting b2 agonist. However I was uneasy at my lack of expertise in spirometry and I took time to look at his reading from the asthma clinic. On doing this I realised that spirometry had shown a RESTRICTIVE defect. This was not an asthmatic pattern.

What thoughts or reflections do you have in relation to this case?

Spirometry and nurse led asthma/COPD clinics are a new development in our practice. It is quite easy to assume that any objective reading such as spirometry is a better measure of a clinical condition than your own clinical estimate and simply rely on the reading. We had only had one session on interpretation of spirometry results and as I didn't feel confident in this I did not question the nurse's actions and interpretation of the test.

Again using a standardised management protocol such as the BTS guidelines tends to make you move from step to step without questioning why the patient is not getting better. Our treatment would have been perfect – ***if the patient had had asthma!***

What learning points have emerged from this case for you?

If as a practice we are going to offer enhanced services such as nurse led asthma/COPD clinics with spirometry we must all be fully versed in what the tests are and mean.

Protocols for treatment of chronic illness are very important to improving the quality of care, but we must treat the patient and not simply follow the protocol.

How will this learning be used in future?

New BTS guidelines are out soon and we need to keep up to date here.

A further reinforcement session on use and interpretation of spirometry has been arranged for the practice.

Supporting case record available? Yes ☐ No ☐

Signed…… Date 12/07/03

Name David Adams