Clinical Effectiveness
South East London

ASTHMA INHALER CHANGE - CLINICIANS' FREQUENTLY ASKED QUESTIONS

Switching from short acting beta agonist (SABA) to combined inhaled corticosteroid /long-acting beta agonist (ICS-formoterol) inhalers:	
Why switch?	SABA-only increases asthma exacerbation risk. ICS-formoterol treats inflammation, provides quick relief and offers longer lasting relief.
But patient feels fine with SABA?	Inflammation can be hidden; ICS-formoterol improves long-term control and reduced exacerbation risk.
SABA is enough for asthma with infrequent symptoms.	No – even patients with infrequent symptoms can have serious exacerbations and should move to combined ICS-formoterol.
But I won't get instant relief with ICS-formoterol?	Relief starts in 1–3 minutes and lasts ~12 hours, much longer than with SABA alone.
Are daily inhaled steroids safe?	As they target the lungs directly, inhaled steroids can be used at much lower doses (in micrograms) resulting in lower systemic exposure and fewer side effects compared to oral steroids (in milligrams) that also have systemic side effects. A single ICS-formoterol inhaler used as-needed delivers steroids only during symptoms, reducing overall steroid use compared with fixed daily doses. Early increase in ICS, when symptoms worsen, can also prevent progression to asthma exacerbation and therefore can reduce oral steroid use.
Are LABAs (formoterol) dangerous?	Formoterol should always be combined with an ICS for safe use.
Steroid withdrawal fears?	Inhaled steroids are unlikely to cause withdrawal when used at low to moderate doses. Patients on high dose ICS should be provided with a steroid emergency card.
What if pharmacies issue SABAs without GP input?	Flag frequent use and coordinate with local pharmacies. Pharmacies are encouraged to identify patients prescribed SABA monotherapy and will refer these patients back to GPs. Remove SABA from repeat; pharmacies only issue emergency supplies for regular repeat medicines.

Switching from metered dose inhaler (pMDI) to dry powder inhaler (DPI) (as part of a shared decision - making process *with* the patient. DO NOT BLANKET SWITCH)	
Why switch?	Many patients find DPIs easier to use. All DPIs have a dose counter. They do not require a spacer for optimal drug delivery. DPIs have a lower carbon footprint and are eco-friendly. One SABA pMDI = 180-mile car journey in emissions. Ensure prescribing is by brand name so that devices are not switched & the patient/parent/carer are assessed on whether they can use the device.
Patient prefers spray inhaler?	Ask why and address this as DPI use often aligns better with natural breathing patterns.
"I can't inhale strongly enough?"	Most older children and adults have an inspiratory effort sufficient for a DPI. It is important to assess technique before prescribing. Tools such as whistles and In-Check dial devices are available.
"DPI irritates my throat"	To relieve this rinse mouth, brush teeth, sip water, or use mouthwash. Review technique to ensure correct usage and avoid inappropriate medication deposition.
DPI is too difficult due to arthritis or weak hands?	Use simple devices (e.g. click-to-use).
My patient insists on a pMDI with spacer?	Acceptable if technique and adherence are good. The greenest/best inhaler for your patient is the one the patient can and will use. Prescribe a formulary approved pMDI; Vivaire for Maintenance and reliever therapy (MART). Or if prescribing separate ICS & SABA: Airomir or Salamol (not Ventolin pMDI).
General FAQs	
Explaining asthma simply:	Focus on inflammation; use visual aids: Asthma Pathophysiology | Severe Asthma Toolkit.
Taste/feel of new inhaler is different?	Reassure - effectiveness isn't linked to taste. Tasting the medicine can be a sign of poor technique. Review technique.

Asking for multiple SABA inhalers, including for different locations/bags?	This may indicate poor control; ICS-formoterol reduces reliance and improves control. Inhalers should be kept on the person (n.b. medication policies may differ between schools). In children and young people, multiple inhalers are often requested especially if parents are separated or child has other carers. However, these are not required every month. Primary school children: the inhaler and spacer should be kept in the classroom. Secondary school children: should carry their inhaler (and associated spacer, if one is required) themselves. (See Asthma friendly schools guide & Supply of salbutamol inhalers to schools – pharmacy guide).
Patient is anxious about change?	Acknowledge, reassure, and use teach-back (Assess, Choose & Train). Offer phone or face to face review in 2-4 weeks' time to assess symptom control. Co-create an asthma action plan for better understanding and reassurance.
Patient declines to switch?	Respect decision, explain benefits, and offer follow-up. Ensure current MDI technique is appropriate – use 7 steps to inhaler technique.
Encouraging consistency across primary care team	Use shared scripts, be consistent in messaging and ensure there is training.
Environmental considerations	Encourage patients to return unwanted or used inhalers to community pharmacy for appropriate disposal and/or recycling.

Key Advantages to Emphasise

- Better control and fewer symptoms
- Reduced risk of attacks/hospitalisation
- Fewer doses with more effective meds
- Simplified prescriptions
- Easier use and environmental benefits

Tips for Successful Conversations

- Respect concerns
- Use simple language
- Normalise non-adherence
- Explain pathophysiology

- Demonstrate technique
- Use teach-back
- Personalise approach

Clinician Reminders

- ICS/formoterol (AIR/MART) is guideline-recommended
- SABA-only or poor ICS adherence increases risk
- Inhaler choice should consider ability, preference, and environmental impact
- Best inhaler = one patient can and will use
- Don't forget to co-create an asthma/ MART action plan

References

Global Initiative for Asthma (GINA) 2024. GINA 2024 Strategy Report
NG245 Overview | Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) | Guidance | NICE
Greener Practice Asthma Toolkit - Greener Practice
Severe Asthma Toolkit: Asthma Pathophysiology | Severe Asthma Toolkit