

Referral Guide: Adult Respiratory Referrals

Please ensure referral letters and forms demonstrate adherence to the guidance below or state specific clinical indications for variance from the guide.

This guide has been developed by NHS Oldham CCG in association with the Pennine Lung Service and Primary Care Oldham LLP (Referral Gateway provider).



Pennine Lung Service



Primary Care Oldham LLP

Clinical Presentation

What should be included in a respiratory referral?

- **Respiratory history**
Please include nature and duration of symptoms, smoking history (including pack years), functional status and relevant quality of life information (to support shared decision making), and where relevant occupational and exposure history.
- **Medications and allergy information**
Please provide an up to date list of current and past medications, and allergy information.
- **Recent chest x-ray report**
Please provide report of chest x-ray taken 'within the timescale of current symptoms' and generally within 3 months of referral date.
- **Relevant blood tests**
Please provide results of recent blood investigations including full blood count.
- **Spirometry and other lung function**
Please provide results of any spirometry to include flow volume loop and volume/time trace, peak flow and resting oxygen saturation.
- **Body mass index**

Suspected Lung Cancer – refer to two week wait pathway and referral proforma

Please provide eGFR to support pre-clinic CT imaging if needed.

Chronic Obstructive Pulmonary Disease

Key information plus...

- + **MRC Dyspnoea Scale** : level of physical function;
- + **Flare-up (exacerbation) history**: number of exacerbations and hospital attendances in past 12 months;
- + **Sputum sampling**: results of any previous cultures and antibiotics prescribed.

Good Practice Points

- Please review inhaler medications and check inhaler technique;
- Consider pulmonary rehabilitation for MRC ≥ 3 ;
- Consider additional causes of breathlessness including lack of physical fitness, anxiety and panic attacks;
- Low BMI consider nutritional support; nutritional risk can be calculated using the [MUST score](#);
- Impact of COPD can be quickly measured using the [COPD Assessment Test](#);
- Guidelines at [NICE COPD guideline 2010](#).

Asthma

Key information plus...

- + **Peak flow record**: twice daily for two weeks with symptom diary, more frequent ;
- + **Flare-up (exacerbation) history**: number of exacerbations in past 12 months and steroid history;
- + **History of atopy**: please include any known triggers.

Good Practice Points

- Please review inhaler medications and check inhaler technique;
- Step treatment up or down as per [BTS/SIGN Asthma Guidelines 2012](#);
- Eosinophils (on FBC), elevated IgE and aeroallergen specific IgE and/or skin prick testing may support allergic asthma;
- Asthma control can be self-assessed using the [Asthma Control Test](#).

Breathlessness

Key information plus...

- + **heart disease risk & history**: where relevant please provide details of full cardiac history including previous cardiac investigations;
- + **MRC dyspnoea scale** : level of physical function and impact on QoL

Good Practice Points

- Consider additional causes of breathlessness including lack of physical fitness, anxiety and panic attacks;
- If cardiac breathlessness suspected consider brain natriuretic peptide (BNP);
- For *severe intractable* breathlessness consider low dose opiates and benzodiazepines, and non-pharmacological interventions (breathing control, hand held fan).

Bronchiectasis

Key information plus...

- + **MRC dyspnoea scale**: level of physical function;
- + **Flare-up (exacerbation) history**: number of exacerbations and hospital attendances in past 12 months;

- + **Daily sputum volume:** if available please send results of any previous sputum cultures and antibiotics prescribed.

Good Practice Points

- Long term antibiotics may prolong exacerbation free periods in patients with ≥ 3 exacerbations per year however benefits should be weighed up against side effects and development of antibiotic resistance – please seek specialist advice;
- Guidelines available at [BTS Guidelines for Non-CF Bronchiectasis 2010](#).

Interstitial Lung Disease

Key information plus...

- + **MRC dyspnoea scale:** level of physical function and impact on QoL;
- + **Occupational, exposure & drug history:** drug induced lung disease may rarely be caused by nitrofurantoin, statins & disease modifying anti-rheumatic drugs. Drugs causing respiratory disease can be searched on [Pneumotox » Drug](#).

Good Practice Points

- Consider referral to the specialist ILD (pulmonary fibrosis) clinic
- Progressive breathlessness plus crackles on examination may suggest pulmonary fibrosis, termed 'idiopathic' when no cause identified and with characteristic HRCT appearances (UIP), important given [NICE Guideline for Idiopathic Pulmonary Fibrosis 2013](#)
- ILD covers a wide range of lung conditions included in the [BTS Guidelines for Interstitial Lung Disease 2008](#)

Chronic Cough

Key information plus...

- + **List of medications trialed for chronic cough:**
- + **Drug history:** please consider potential side effects of ACE inhibitor therapy.

Good Practice Points

- Most causes of troublesome cough (with normal CXR) reflect an aggravant such as asthma, drugs, gastro-oesophageal reflux or nasal problems in a susceptible individual.
- Guidelines at [BTS Recommendations for Management of Cough in Adults 2006](#)

Oxygen Assessment

Key information plus...

- + **Confirmed diagnosis of chronic lung condition:** treatment optimized;
- + **Oxygen saturation:** readings at least 2 weeks apart and both $< 92\%$;
- + **Full blood count.**

Good Practice Points

- Established evidence for long term oxygen therapy (LTOT) in COPD has been extrapolated to other chronic lung conditions;
- All patients should be formally assessed for LTOT via the Oxygen Service.

Home Oxygen Service

North Manchester General Hospital, Delaunays Road, Crumpsall, Manchester M8 5RB Fax to: (0161) 604 5541 [Internal 45541] Phone: (0161) 922 3175 [Internal 43175]

Sleep Clinic

Key information plus...

- + **List of medications trialed for chronic cough:**
- + **Drug history:** please consider potential side effects of ACE inhibitor therapy.

Good Practice Points

- **Epworth Sleepiness Scale:** please provide reason for referral if ESS < 11
- **Body mass index :** details of collar size is also helpful;
- **Occupation and driving:** See also [DVLA guidelines](#): does the patient drive for a living?
- **Full blood count and thyroid function;**
- **Oxygen saturation**

Suspected or Confirmed Tuberculosis

If suspected or confirmed then please refer **URGENTLY** via TB Referral Pathway (rather than through Choose & Book)

Tuberculosis is a bacterial infection that usually affects the lungs, though it can affect any part of the body.

Although TB is spread through the air when people cough or sneeze, it takes a lot of close, lengthy contact with an infectious person to catch the disease.

Anyone can catch TB, but some people are at more risk than others. These include people who:

- have been in close contact or live with someone who has infectious TB
- have lived, worked or stayed in parts of the world where TB is common, e.g. sub Saharan Africa, south-east Asia and some eastern European countries.
- are unable to fight off infection due to (immunosuppressed) illness (e.g. HIV, diabetes) or treatment.
- are very young or elderly - their immune systems tend to be weaker than those of healthy adults
- have a poor diet or do not eat enough to stay healthy e.g. homelessness or sleeping rough
- are dependant on drugs or misuse alcohol
- living in poor or crowded housing conditions, such as remand centres and prisons

TB is medically managed by specialist consultants on each site. If you suspect that you have a patient with TB, please refer to the TB team:

NMGH – Fax 0161 720 2680

Dr Alec Bonington (TB Lead Physician Infectious Disease Unit) - secretary 720(4) 2734
Dr Javier Vilar
Dr Andy Ustianowski - secretary 922(4) 3097
Dr Tom Blanchard
Dr Katherine Ajdukiewicz – secretary 918(4)4544
Dr Ed Wilkins – secretary 720(4)2733

FGH, RI

Dr Shona McCallum – secretary 01706 517088 (57088)

ROH – covered by NMGH team

Dr Bonnington/ Dr Ajdukiewicz - secretary 720-2734 / 918(4544)

Fax 0161 720 2680

The TB Nurses are closely involved in the management of all patients with TB. They are responsible for notifying new cases of TB to Public Health England, identifying and screening contacts and supervising medications. The TB nurses will also offer new entrant screening and if needed BCG vaccination

The TB nurse teams:

NMGH Sue Humphreys TB Specialist Nurse – Office 720 2394, mobile 07792954047, fax: 0161 720 2680

Karen Hobson TB Support Nurse

HMR, ROH, FGH Chris Richardson TB specialist Nurse

Jill Reid TB Support nurse

Virginia Gardiner TB Support nurse

Contact number Tel: 01706 517178 **Fax: 01706 517717**

Good Practice Points

Occasionally patients with suspected TB are found to have lung cancer.

In referrals for longstanding cough, where a recent chest X-ray is normal, pulmonary tuberculosis and lung cancer are both unlikely. In the absence of other red flag symptoms patients can be referred through C&B as they are at present though sputum samples can be still sent.

See also Guidelines at: [NICE Tuberculosis 2011](#).

Triage Protocol for Adult Respiratory Referrals

Group A Mild conditions	Group B Moderate conditions	Group C Severe conditions
<i>Should be reviewed and treated by family doctor and/or practice nurse</i>	<i>Suitable for review in community based clinics</i>	<i>Should be referred directly to secondary care (in some cases symptom control may be started by primary care team)</i>
<ul style="list-style-type: none"> ▪ Stable COPD ▪ Stable asthma ▪ Subacute cough (< 8 weeks duration) with no other clinical concern ▪ Explained and controlled breathlessness with no other clinical concern ▪ Smoking cessation ▪ Referral for pulmonary rehabilitation MRC≥3 ▪ End stage lung disease requiring palliative care 	<ul style="list-style-type: none"> ▪ Nurse led COPD ▪ Patients with COPD with uncontrolled symptoms and/or frequent exacerbations ▪ Nurse led asthma ▪ Patients with persistent asthma symptoms not controlled by GP or practice nurse interventions ▪ Community Consultant Clinic ▪ Unexplained or disproportionate breathlessness ▪ Chronic cough ▪ Abnormal chest x-ray with no red flag signs and no suspicion of cancer ▪ Abnormal lung function with no obvious underlying diagnosis ▪ GP request for non-urgent advice 	<ul style="list-style-type: none"> ▪ Suspected lung cancer (red flag signs and two week wait referral) ▪ Abnormal CXR suspicious for lung cancer (TWW) ▪ Pleural effusion (+/- TWW) ▪ Suspected or confirmed tuberculosis (urgent referral) ▪ Severe & difficult asthma <i>Defined as persistent symptoms and/or frequent exacerbations despite treatment at step 3, 4 or 5</i> ▪ Interstitial Lung Disease ▪ Occupational lung disease ▪ Pulmonary hypertension ▪ Bronchiectasis (severe) ▪ Obstructive sleep apnoea, obesity related respiratory failure ▪ Respiratory failure due to neuromuscular or chest wall disease ▪ Long term and ambulatory oxygen assessment <u>via Oxygen Service Referral</u> ▪ Referral for in-flight oxygen testing