Inhaler Decision Guide

Choosing the class; technique & switching troubleshooting

CLINICAL PATHWAY

Use this for the **clinical thinking**; pin the Lung Foundation Australia and National Asthma Council wall posters for device photos, brand names and PBS-restriction symbols (both updated annually). Over 70% of patients have an inhaler technique error — check at every visit; the wrong device can mean no treatment at all.

Choosing the inhaler class

Match the clinical scenario, then look up the brand on the wall chart.

1	**Asthma, mild/new** — ICS-formoterol PRN (AIR); replaces SABA-only reliever
2	**Asthma, frequent sx** — ICS-formoterol MART; one inhaler for maintenance + reliever
3	**Asthma-COPD overlap** — ICS-formoterol; commonly covers both, see the NAC chart
4	**New COPD, Group A** — LAMA or LABA monotherapy; a single bronchodilator is enough
5	**New COPD, Group B** — LABA+LAMA combination; outperforms monotherapy for symptoms
6	**COPD Group E/flares** — LABA+LAMA; add ICS only if eosinophils ≥300 cells/µL
7	**Still flaring, frail, or cost-limited** — triple therapy (single device), or consider Respimat/breath-actuated/generic options

EXACT BRANDS & PBS CODES

For device photos, brand names and the current PBS-restriction legend (unrestricted / restricted / authority symbols), use the live Lung Foundation Australia COPD chart and National Asthma Council Asthma & COPD chart — replace your wall copy at each annual update and read the legend printed on that version.

TECHNIQUE BY DEVICE

- **pMDI** (use a spacer) — slow, steady breath; wait ~30 sec between puffs; mistake: inhaling too fast, or towel-drying the spacer.
- **DPI** (Turbuhaler/Accuhaler/Ellipta/Breezhaler/Handihaler) — fast, forceful single breath; pierce capsule devices and listen for the rattle; mistake: inhaling too slowly.
- **Respimat** — slow mist, no need to rush; mistake: inhaling before the press.
- **Autohaler** — slow, steady breath; auto-triggers, so needs less coordination; mistake: stopping when it clicks.

SWITCHING LOGIC

- Poor technique on a DPI → switch to pMDI + spacer (a DPI needs a fast inhalation).
- Poor technique on a pMDI → switch to Autohaler or Respimat (breath-actuated).
- Polypharmacy/adherence concerns → consolidate onto a single combination inhaler.
- Still symptomatic on dual COPD therapy → step up to a single triple-therapy device.

ICS STEP-DOWN IN COPD

Routine ICS withdrawal in stable triple therapy is **not** generally recommended (GOLD 2025). Reserve step-down for ICS started inappropriately, no response, recurrent pneumonia, or significant side-effects — low blood eosinophils (commonly <100 cells/µL) support a low-ICS-responsiveness call. Step down gradually (ICS+LABA+LAMA → LABA+LAMA), document the rationale, and monitor for symptom worsening.

■ SAFETY

- Check technique at every visit — the single highest-yield, lowest-cost intervention
- Multiple ICS-containing inhalers → check for unintentional duplication
- SABA reliever use > 1 canister/month signals uncontrolled asthma — review urgently
- Always document the rationale when stepping down ICS in COPD

■ RED FLAGS / REFER

- ≥2 oral corticosteroid courses in 12 months — step up the controller or refer
- Worsening despite triple therapy — refer respiratory; consider biologics or alpha-1 testing
- Diagnostic uncertainty between asthma, COPD, and overlap
- Complex regimens — consider an annual pharmacist MedsCheck and asthma/COPD educator referral