A Visualized Approach to Inhaled Respiratory Medications – Follow up Questions and Answers

1. If a patient will not quit smoking, despite teaching and education, how effective is the Duoneb?
   Duoneb will still be effective even if the patient is smoking by helping with bronchodilation and easing the dyspnea. But of course, smoking cessation will help maximize its effect.

2. What is your recommendation for prednisone taper following 5 day course of 40 mg with COPD exacerbation? (Can you clarify the prednisone taper you recommended?)
   Prednisone 40mg for 5 days, then Prednisone 30mg on day 6, Prednisone 20mg on day 7, Prednisone 10mg on day 8, Prednisone 5mg on day 9 and then discontinue.

3. Do you ever use inhaler MS per SVN tx?
   Nebulized morphine sulfate can be used for dyspnea. However, studies have shown that it provides no extra advantage over oral Morphine (tablet or solution, which can be given sublingually). It is generally more expensive and the preservative free formulation of Morphine has to be given. Additionally, most likely when the patient is using the nebulized formulation of Morphine, they are swallowing the Morphine and providing relief that way. The time to symptom relief is very similar between nebulized Morphine and oral Morphine.

4. If a patient is on a daily PO dose of prednisone or equivalent, what mg dose is enough to justify discontinuing an ICS? (Xmg of prednisone PO is equal or greater than Ymg of budesonide)
   There really is no equivalency between a PO Prednisone and nebulized Budesonide. However, if the patient is already on an oral daily dose of Prednisone and on an ICS, this is a duplicate therapy and may be causing more adverse effects. Therefore the Budesonide should be discontinued regardless of the dose of Prednisone or equivalent. It is generally recommended that patients be on the lowest dose of oral Prednisone possible due to its systemic side effects. A typical dose for Prednisone would be 10mg daily, but it can be titrated up to effect.

5. How do we manage covering medications for hospice when they are on duplicate therapies and refuse to change?
   Unfortunately if the inhaled medications are being used for a condition related to the patient's terminal diagnosis, then the hospice is required to cover the medication, even if they are duplicate therapies and the patient refuses to change it.

6. When you are eliminating duplicate therapies, should the dosages of the medications that are left? It is hard to eliminate medications without replacing them with something, from a patient perspective. What would you say to a patient with this concern?
   I would tell the patient that having more than one medication that works the same way does not improve symptoms, but puts them at risk for adverse effects. Medications generally work well if the dose is within a certain window. If the dose is too high, it can cause them more harm than good. When discontinuing duplicate therapies, you do not need to add more to the dosage of what the patient has left unless the dosage of the left over medications have not been maximized.

7. If Duonebs are ordered PRN and routine, is there a max dose in 24hrs, or how frequently should this medication be given at a max?
   The typical maximized dose for Duoneb is 1 vial (3ml) QID with a Q4 hour PRN dose.