Minutes of the Ordinary Meeting of The Leicester Medical Society
Held as a Webinar on 3rd November 2020
There were 55 participants

Breathlessness…..implementing a symptom-based clinic and spreading an approach to the wider system

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Dr Evans was introduced by the President, Dr Darren Jackson.

Breathlessness is a normal physiological response to exercise - but it becomes abnormal when daily activities are affected. It is influenced by age, weight, cardiorespiratory fitness and central perception. 5% of patients attending General Practitioners and 21% of patients within medical admissions complain of breathlessness. The definition of Chronic Breathlessness Syndrome is still being honed and will provide a common language for researchers. Initial issues are to determine if there is something serious underlying it and what can be done to help. Quite clearly for the patient it is a frightening time.

The symptom can lead to a spiral of inactivity leading to anxiety, depression and isolation. Correct diagnosis and disease specific therapy must be complemented by pulmonary rehabilitation which encompasses education, breathing control and exercise. Generic Exercise Rehabilitation was the focus of Dr Evan's PhD Thesis and recognised that other aspects of chronic disease management could be addressed within one generic multidisciplinary team for breathlessness.

Chronic breathlessness presents a diagnostic challenge for GPs. 2/3 are caused by cardiorespiratory disease and 50% (in adults older than 40 years) are caused by five common conditions eg. COPD, Heart Failure, Anaemia, Obesity and Anxiety. The current pathways for patients being referred to secondary care were scrutinised. The experience of the patient included the length of time it took to make a diagnosis, see a physiotherapist and the shuttling between respiratory and cardiology outpatient departments which adopted different methods of investigation. The answer was to develop an integrated symptom-based diagnostic pathway for investigation and management.

A wide ranging team with community representation and including hospital management was brought together in Leicestershire to look at the issue. A six month pilot of a Breathlessness Clinic held twice per month was put in place. A Consultant cardiologist, Consultant respiratory physician and a respiratory physiotherapist were in attendance as part of a team. The group screened existing referrals to cardiology and respiratory OPDs and ensure a complete panel of investigations followed. It aimed to establish whether referrals would be necessary if this panel had been performed in the primary care setting. In addition a series of questionnaires were completed to establish eg activity and anxiety/depression scores. Each clinic, part of which was 'one stop' was followed by a multidisciplinary team discussion.

The outcome was that a fifth of patients had been initially referred to the 'incorrect' specialty. Within the clinic using a 'panel of investigations' comprehensive assessments of the causes of the breathlessness were identifying multiple co-morbidities. There were marked reductions in waiting times for appointment, diagnosis and the help of a physiotherapist. The DNA rate was slashed from 18% to 4% and the new to follow up ratio inverted so that many more new patients could be seen. Another conclusion was that joint cardiorespiratory working was valuable and avoided 30% of patients having inter specialty referrals. There is a need to increase the utilisation of simple tests for the diagnosis of breathlessness in primary and secondary care. The result has been the commissioning of this integrated symptom based service which could provide a template for other specialties.

A National Institute for Health Research (NIHR) study aims to establish whether earlier diagnosis of breathlessness in Primary Care (Breathe DeEP Study) using a simple panel of investigations is clinically and cost effective. This would require a large multi centre Random Controlled Trial to answer the questions.
A feasibility study aims to look at the mechanics of recruitment of practices, patients, trial design, the concept of ‘usual care’, data and outcome measures amongst other criteria.

The impact of the **Covid19** pandemic on the Breathlessness Clinics has been profound leading to reduced referrals, telephone consultations, referrals without usual investigations and devastating the long term plan to improve care. In addition patients without a specific diagnosis feel left out and may use either engaged or disengaged coping strategies for managing their breathlessness.

The condition itself is recognised as a multi system disease. The often profound long term (Long Covid) consequences are common and currently not well understood. In Leicester patients are assessed in a weekly multi disciplinary clinic similar in structure to the Breathlessness Clinic. The aim is to establish recovery needs and support, identify any reversible pathology and long term sequelae.
It adopts a holistic strategy. Other Specialists are brought to the MDT where required eg. Nephrologists. This approach has been advocated nationally and funded.
An NHS-E website “Your Covid Recovery” provides an online rehabilitation service to provide personalised support to patients. Over 100,000 people have used the digital platform being developed by the University of Leicester.
NICE clinical guidelines on the support that patients with Long Covid should receive are expected in November. Designated Long Covid Clinics are being developed.
Dr Evans and her colleagues, researchers at the University of Leicester are involved with the NIHR Research into **Long Covid** and are making a significant national contribution to knowledge about this challenging condition.

A series of questions were answered by the speaker. The importance of smoking cessation as part of the management of breathlessness, dysfunctional breathing, the difficult diagnosis of asthma in primary care, the value of exercise in non-hospitalised patients following Covid19, and pulmonary fibrosis were among topics discussed.

COPD Chronic Obstructive Pulmonary Disease
OPD   Out-Patient Department

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