

COPD Post Acute NIV pathway

Acute exacerbation of COPD¹ requiring NIV (pH<7.35, PaCO₂>6kPa)

Patient able to tolerate NIV with clinical improvement (pH>7.35)

Suspected chronic hypercapnia² with no evidence of obesity or OSA³

1. Diagnosis of COPD
 - a. Established diagnosis of COPD (FEV₁/FVC <0.7) OR
 - b. Suspected clinical diagnosis of COPD (>10 pack year history, progressive dyspnoea, cough, sputum, recurrent LRTI)
2. Features of chronic persistent hypercapnia
 - a. Admission cBE >2 / cHCO₃ >28 mmol/L
 - b. PaCO₂ > 7kPa 2 weeks post resolution of respiratory acidosis
3. Obesity (BMI > 30kg/m²) or suspected OSA from clinical history then follow obesity related respiratory failure management

Clinical stability off NIV

EPR Referral to LFU for HOT review within 2-4 weeks

Unable to wean from or clinical instability off NIV

Liaise with LFU for consideration of NIV setup pre-discharge

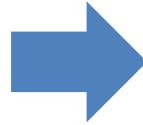
Obesity Related Respiratory Failure Post Acute NIV Pathway

Admission with
decompensated hypercapnic
respiratory failure
(pH <7.35 PaCO₂>6kPa)

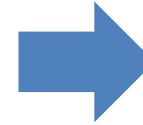


Tolerates acute NIV with
clinical improvement but
persistent hypercapnia
(pH>7.35 PaCO₂>6kPa)

Suspected obesity¹ related
chronic respiratory failure² and
sleep disordered breathing³



Refer to Lane
Fox Team⁴
to establish
CPAP on William
Gull prior to
discharge



EPR Referral to LFU
for HOT review
within 2-4 weeks

1. Obesity
 - a. BMI > 35 kg/m²
2. Features of chronic hypercapnia
 - a. Admission cBE >2 / cHCO₃ >28 mmol/L
 - b. PaCO₂ > 6kPa at recovery of acute episode
3. Features of sleep disordered breathing
 - a. STOP-BANG (**S**noring, **T**ired, **O**bserved to stop breathing (Apnoea), **H**igh blood pressure, **B**MI >35 kg/m², **A**ge > 50 years, **N**eck Circumference > 43cm (M) and 41cm (F), **M**ale Gender; 3+ OSA likely and 6+ OSA very likely)
4. To assess for clinical stability off NIV