Milton Keynes NHS Primary Care Trust

Milton Keynes Hospital NHS NHS Foundation Trust

MILTON KEYNES NHS TRUSTS
MEDICINES AND THERAPEUTICS COMMITTEE

Minutes of the meeting held on Tuesday 15th November 2011
At 1p.m. in Eaglestone Function Room

PRESENT:
(Chair)
Dr V Jeevanathan (VJ)

MKH NHS Fdn. Trust	MK NHS PCT
Niall Ferguson (NF)	Janet Corbett (JC)
Folake Kufeji (FK)	Helen Chadwick (HC)
	Sheila Begley (SB)
	Nigel Fagan (NFa)

Minutes: Jean Kelly (JK)

Others in attendance: Chinwe Osuchukwu (CO) representing Prem Roy (PR), Mansoor Raza (MR), Jasper Katumba (JasK), George Macfaul (GM)

1. Welcome, apologies for absence and introductions
VJ welcomed MR and CO to the committee with an introduction of the Committee members.
GM and JasK entered the meeting at a later stage.
Apologies received from Sarah Whiteman (SW), Wendy Rowlands (WR), Essam Hassan (EH), Richard Butterworth (RB), Anne Jenkins (AJ).

2. Declaration of conflicts of interest
None declared.

3. Minutes of last meeting
The minutes were agreed as an accurate reflection of the meeting.

4. Matters arising from previous minutes

Mexiletine application
FK to contact Dr Hilton-Jones. **FK**

Neutropenic Policy (For Information only)
This Milton Keynes hospital trust policy was presented to the committee for information only. JC expressed concern that the algorithm did not match the content of the policy. FK pointed out that the algorithm did refer the user to Appendix 1. VJ advised JC to raise any concerns with the author of the policy as it has already been approved and in use and only brought to M&TC for information.

Botox Maxfax
JC reported that ongoing approval has now been given for the 20 patients currently receiving treatment. Prior approval will be required from the exceptional patients panel for any new patients.

5. South Central Priorities Committee MOBBB decision

a) **SCPC Policy 46** – JC highlighted that the SCPC had published a decision on the use of Intravitreal Bevacizumab (Avastin) in Wet Age Related Macular Degeneration (AMD) in May. She is aware that this has not currently been implemented in the trust. Would like the committee to note that Lucentis is still being used in preference to Avastin which is contrary to the policy. Action: FK to raise with Mr Bates. **FK**

b) **SCPC Policy 47a** – JC also reported that the recommendations of the policy for Treatments for erectile dysfunction were not currently being followed by the urologists.
Action: FK to inform urologists: Mr Andrews, Mr Anjum and Mr Selim. **FK**

6. Drug formulary

New medicine applications:

a) **Ertapenem**

MR presented his application to the committee. He stated that ertapenem is a carbapenem not currently equivalent to those on the formulary. It's main advantage is it can be administered once daily. This means that this drug would be very useful for use within the OPAT setting as this service has just started. The would not be used in all patients but targeted at the those patients with sensitive isolates for the treatment of the following;

i) ESBL UTI's in the OPAT setting. MR aware ertapenem is currently unlicensed for this indication and the unlicensed medicines application will need to be completed if approved. **MR**
ii) Diabetic foot infections.
iii) Very rarely patient discharged with an intrabdominal sepsis.

FK asked for clarification on the role of ceftriaxone and MR confirmed that ceftriaxone will still continue to be used in preference to ertapenem where it can be used unless a patient had definite *Clostridium difficile*.

Decision: APPROVED, restricted to use by consultant microbiologist only. **FK**

b) **Avonex**
c) **Betaferon**
d) **Copaxone**
e) **Rebif**

Applications b – e above were not considered as RB was not present. These applications will be postponed to the next meeting. **RB/FK**

f) **Colecalciferal liquid**

CO presented this application on behalf of PR. She highlighted that vitamin D deficiency is now quite common in the paediatric population and it is quite paramount that this is treated to prevent long term problems with rickets. The treatment proposed is quite acceptable to the paediatric population is also easy to monitor. In support of the application, guidelines for its use had also been produced. NFa suggested that Appendix 1:Treatment of vitamin D deficiency algorithm should make clear which blood tests need to be rechecked. This is to make it clearer to GPs who would be occasional users of the guideline otherwise they would have to read through the whole policy to ascertain what blood tests to check. HC fed back that feedback from the initial consideration

of the application at the prescribing group was that GPs would be unhappy to prescribe the higher dose in children but would be happy to take up prescribing at the maintenance stage. JC also highlighted that in addition to the clinical reason there would be huge cost implications to the health economy in the unlicensed colecalciferol being prescribed in primary care, therefore it would be preferable for this to remain in secondary care.

Decision: APPROVED for addition to the formulary. For use in secondary care only. Guidelines also approved pending changes. **CO/JC/FK/ Cathy Lau**

g) **Budesonide**

GM explained that there were three main conditions for budesonide was needed on the formulary.

i) As an option for patients with small bowel crohns for whom prednisolone would not be suitable. It is nearly as good as prednisolone in terms of the numbers needed to treat and has a better systemic side effect profile.

ii) A newer indication for its use would be microscopic colitis, which is characterised by quite chronic watery diarrhoea more commonly in middle age women. Budesonide has been the principally studied medicine, but other drugs have been tried including bismuth and asacol. However, budesonide has been found to be have a very high rate of response with patients reporting symptoms being "switched off like a tap". Doses are usually tapered off over 2-3 months from 9g to 6g to 3g and then stopped. About 50-70% of patients will stay in remission. For patients who do not stay in remission choices are either to try another course of budesonide or to give another drug. The committee queried if prednisolone would be a suitable option to which GM answered that it had been trialled in this condition but for whatever reason had not been found to be efficacious. Budesonide in gastroenterological circles was considered the drug of choice.

iii) There have also been conflicting trials on the effectiveness of budesonide in treating auto-immune hepatitis. This indication however is not part of the current application.

Decision: APPROVED for addition to the formulary. For crohns disease, prednisolone would remain first choice. Where this is not suitable, Budenofalk would be 1st line and Entocort CR as 2nd line where there are compliance issues. **FK**

h) **Moviprep**

GM stated that moviprep is widely used across the country and highlighted the reasons why this medicine is required on the formulary. These were mainly; lower volume required which is about half that of Klean- Prep the standard option, better side effect profile due to it's lower volume therefore it has less effects on electrolyte imbalance, improved patient tolerability and same efficacy in terms of bowel clearance. VJ queried how this would be administered in practise. GM replied that patients booked in for a morning scope would have their dose the night before and patients booked in for an afternoon scope would have their dose on the morning of the procedure. This would also be an option for patients at risk of a large volume preparation. FK explained the medicine review did not come up with any evidence to that moviprep was more effective than klean-prep and moviprep was also more expensive, therefore the cost-effectiveness did not balance in the favour of

moviprep. GM explained Tracy Shaul was quite keen to carry out an audit using stock provided by the company currently held in pharmacy to compare the efficacy between moviprep and klean-prep and asked the committees agreement to do this. JC wanted clarification that GPs would not be asked to prescribe this for colonoscopies and was reassured that this would not be the case.

Decision: APPROVAL given for a trial/audit using current stock held in pharmacy. Trial/audit should report back to the committee evidence of the amount of failed colonoscopies and repeat procedures due to inadequate bowel cleansing. This will enable a decision to be made between moviprep and klean-prep. **FK**

i) **Iloprost**

Apologies from AJ, application postponed to the next meeting. **AJ/FK**

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j) **Curosurf**

JasK stated that Survanta (a bovine derived surfactant) is currently being used in the trust but would like to switch over to Curosurf (a porcine derived surfactant) for use in respiratory distress syndrome. Currently 96% of units across the UK are using curosurf and this is widely used across the south central region. This means that a baby may be started here on one agent and if transferred has to change. There is also the worry that survanta may be unavailable next year. JasK stated that the company representative had quoted a different price to that stated in the review by pharmacy. FK reiterated that according to trust policy drug prices must be discussed with pharmacy and not medical staff. Pricing stated in the review is the price at which the pharmacy can currently purchase the medicine. JC was fully in support of the application but was concerned by the lack of information about the number of patients as it is a PBR excluded drug and the cost would ultimately fall on the PCT.
The other indication which it would be used would be meconium aspiration syndrome has already saved a lot of money. This syndrome could cause a deactivation of the little surfactant the baby already has, so by giving artificial surfactant the baby can be rescued preventing the need for nitric oxide or extracorporeal membrane oxygenation (ECMO).
The committee felt there should be a clear set of criteria for its use, and restricted to consultant initiation only. JasK felt this would not be practical as if not treated quickly babies with RDS would go into persistent pulmonary hypertension of the newborn (PPHN) and in other indications would be mostly off-licence as with most prescribing in neonatology. HC commented that the original application was for the licensed indication and not the unlicensed indication to which JasK replied that he assumed the committee would allow the clinician a degree of clinical freedom with respect to use. JasK agreed that he would send the numbers to Cathy Lau.

Decision: Committee requires information on the potential number of patients who will receive Curosurf to allow an assessment of its impact on the PBR budget. JasK to email the number to Cathy Lau.Once received a decision can be made by e-mail. **JasK/JC/FK/ Cathy Lau**

<u>Post-meeting information supplied by Dr Katumba</u>

Estimates are from Information derived from SEND (South of England Neonatal Data system).

Preterm babies needing Surfactant per year	63
Term infants needing Surfactant per year	8
Total	**71**

Post-meeting decision taken
Approved for formulary addition for Consultant use only and in line with the license as requested in the application. Any other use should be with prior approval or Medical Director approval if urgent.
If there is likely to be regular off licence use in other well defined groups then an additional application should be submitted.

k) **Topiramate** **FK**

Committee considered there was a therapeutic gap and need for this medicine on the formulary

Decision: APPROVED. All available formulations were approved for addition to the formulary.

7. NICE guidance

a) **TA235 – Mifamurtide for the treatment of osteosarcoma**

1.1 Mifamurtide in combination with postoperative multi-agent chemotherapy is recommended within its licensed indication as an option for the treatment of high-grade resectable nonmetastatic osteosarcoma after macroscopically complete surgical resection in children, adolescents and young adults and when mifamurtide is made available at a reduced cost to the NHS under the patient access scheme.

b) **TA236 – Ticagrelor for the treatment of acute coronary syndromes**

1.1 Ticagrelor in combination with low-dose aspirin is recommended for up to 12 months as a treatment option in adults with acute coronary syndromes (ACS) that is, people:

- with ST-segment-elevation myocardial infarction (STEMI) – defined as ST elevation or new left bundle branch block on electrocardiogram – that cardiologists intend to treat with primary percutaneous coronary intervention (PCI) **or**
- with non-ST-segment-elevation myocardial infarction (NSTEMI) **or**
- admitted to hospital with unstable angina – defined as ST or T wave changes on electrocardiogram suggestive of ischaemia plus one of the characteristics defined in section 1.2. Before ticagrelor is continued beyond the initial treatment, the diagnosis of unstable angina should first be confirmed, ideally by a cardiologist.

1.2 For the purposes of this guidance, characteristics to be used in defining treatment with ticagrelor for unstable angina are: age 60 years or older; previous myocardial infarction or previous coronary artery bypass grafting (CABG); coronary artery disease with stenosis of 50% or more in at least two vessels; previous ischaemic stroke; previous transient ischaemic attack, carotid stenosis of at least 50%, or cerebral revascularisation; diabetes

mellitus; peripheral arterial disease; or chronic renal dysfunction, defined as a creatinine clearance of less than 60 ml per minute per 1.73 m^2 of body-surface area.

JC asked if cardiology can define its place as it says it's a treatment option in ACS. Can we ask them to say which patient group they envisage it will be used in?

Action: FK to ask cardiologists to clarify its place in therapy as a treatment option in ACS. **FK**

8. Hospital ePACT data

NF updated the committee that the major withdrawal of FP10(HP) across the trust, had resulted in decreased usage of the forms and hence a reduction in the number of items prescribed out of pharmacy opening hours. We still have a nurse prescriber who still uses this as a means by which to get materials for her patients. JC wanted to know if the reduced use of FP10(HP) had resulted in a shift in prescribing to primary care. NF assured her that while some prescribing may have shifted to primary care the majority was being dispensed by the hospital pharmacy and indeed this had resulted in an extra 1000 items per month from practically nil.

Action: NF to find out why they are using it and update the Committee. **NF**

9. Guidelines in development

a) Vitamin D Deficiency in children with normal renal function **CO/JC/FK/ Cathy Lau**

See item 6(f) above. Guideline approved pending changes.

b) **Management of Mammalian Bites**

FK said it is to be used in A&E and establish which antibiotic to use. NF said that the old policy had Doxycycline and that is why it has come here. There was discussion around the choice of clindamycin and HC suggested that metronidazole and erythromycin would be a better option to using clindamycin.

Action: FK to feedback suggestion. **FK/ Wasima Maroof**

M&TC Members Only

10. eFormulary

HC said that it is still being populated and is very time consuming. It is therefore taking longer than anticipated. HC and FK reported that a deadline date set for completion has now been set for end of January 2012. **HC/FK**

11. Terms of Reference

NF apologised as the paper provided at the meeting should have been circulated with the Agenda. VJ requested committee members to send comments to NF. FK asked if the frequency of meetings could be agreed to allow the dates for 2012 to be set as meetings were previously held 5 times a year but as per proposed terms of reference, this would be monthly. All were in agreement for the meetings to continue to hold at 1-2pm on the 3rd Tuesday of the month. JC suggested that room bookings are made for the intervening months pending approval of the terms or reference.

Action:

All committee members to send their comments to NF. **ALL**

JK to arrange a venue for January if possible and frequency should be monthly for every 3rd Tuesday of the month thereafter if agreed. **JK**

12. Confirmation of Dates for 2012

The date of the next meeting is **Tuesday 21st February 2012** , Milton Keynes Community Health Service (previously known as PCT Boardroom) at 1pm, unless otherwise informed of confirmation of meeting for January.

M&T Committee Meeting Schedule for 2012			
Month	**Venue**	**Day**	**Time**
January		January	13:00 - 14:00
February	Former PCT Boardroom	21st February	13:00 - 14:00
March	TBC*	20th March	13:00 - 14:00
April	Eaglestone restaurant function room	17th April	13:00 - 14:00
May	TBC*	15th May	13:00 - 14:00
June	Eaglestone restaurant function room	19th June	13:00 - 14:00
July	TBC*	17th July	13:00 - 14:00
August	TBC*	21st August	13:00 - 14:00
September	Eaglestone restaurant function room	18th September	13:00 - 14:00
October	TBC*	16th October	13:00 - 14:00
November	Eaglestone restaurant function room	20th November	13:00 - 14:00
December	TBC*	18th December	13:00 - 14:00

*To be confirmed