PRESCRIBING NEWS

NHS Milton Keynes

April 2012

Update from Prescribing Group, March 2012

- Dr Ahmed Nasiri has resigned from the group. He was thanked for his contribution to the prescribing agenda over the years as a member of Prescribing Group and as Prescribing Lead. This leaves a GP vacancy. In line with the new CCG structure, the group does not have a representative from the East Neighbourhood so if anyone would like to volunteer, please contact Janet Corbett.
- **The FormularyMK website** has been launched and is accessible by all. It can be found at www.formularyMK.nhs.uk Please use it. Consider saving as shortcut on desktops.
- The DH guidelines on the management of Vitamin D deficiency were discussed. Guidance has been circulated to practices and can be found on the formulary website.
- Ideas for the 2012/13 QoF Medicines Management targets were discussed.
  Please remember to book your visit.

Goodbye and Good Luck

The Pharmaceutical Advisers have said goodbye to three members of the team this month.

Helen Chadwick has taken up the post of Chief Pharmacist at Milton Keynes Community Health Service after 12 years at the PCT. Helen has helped to build the team's relationships with practices during those years and has championed the development of the formulary as well as being the local guru on Patient Group Directions. We will see Helen at prescribing and medicines management meetings representing MKCHS in her new role.

Nikki Hughes will be known to many as our Community Pharmacy Lead. She has worked in and around MK for many years, including almost 10 as part of the pharmaceutical adviser team. Nikki has decided to take early retirement to enjoy her lovely garden and spend more time with her family. Nikki has driven forward developments in community pharmacy and her enthusiasm will be missed.

Laura Lucas has worked with a number of practices as their Medicines Management Technician and helped us make prescribing savings and improve patient experience with their medicines. She has now moved on to be Practice Manager at Bedford Street.

We will miss our former colleagues but wish them well and thank them for their efforts on behalf of the team.

We are hoping to recruit to the vacant posts but in the meantime, please contact Nikki Woodhall or myself if you need any advice.

Update from Medicines and Therapeutics Committee, February and March 2012

- **Mexiletine** was approved for prescription by hospital consultant neurologist **only.** GPs should not be asked to prescribe this unlicensed medicine.
- **Sandocal 1000** was approved for the short term treatment of hypocalcaemia post thyroidectomy. All patients will be followed up in Out-patients at 6 weeks.
- **Sanatogen A-Z Complete** was approved for addition to the formulary as a complete vitamin supplement where needed in line with NICE clinical guideline on nutrition support in adults
- **Tenofovir and Entecavir** are used in the management of Hepatitis C. Both were approved in line with NICE Guidance with Tenofovir approved for first line use and entecavir reserved for cases of treatment failure or pre-selected resistance to tenofovir. Shared care protocols are being developed to support transfer of prescribing to GPs.

Which antibiotic for trimethoprim resistant UTI in the elderly?

You may encounter patients with a UTI who have resistance to trimethoprim and a compromised renal function, so nitrofurantoin is unsuitable. If they are also over 75 or immunocompromised they will be more susceptible to *C difficile* with cefalexin or ciprofloxacin treatment. What should GPs be doing in this situation?

Here is the advice from Naomi Fleming, Antibiotic Pharmacist:

1. Take an MSU and include on the urine sample form that the patient can't take nitrofurantoin due to renal issues, and then microbiology will release more sensitivities giving a choice.

2. Pivmecillinam may be an option although it should not be used as blind treatment as the organism may be resistant to it (although this is still rare).

3. If the patient is penicillin allergic then you cannot use pivmecillinam or cefalexin or co-amoxiclav so you are left with little choice but ciprofloxacin, if sensitive. Then there is an obligation to warn of potential side effects including *C difficile* and tendonitis.

4. If faced with choice of cefalexin or ciprofloxacin then it would be best to go with cefalexin as ciprofloxacin can also cause tendonitis in elderly.

More studies show risks with benzodiazepines

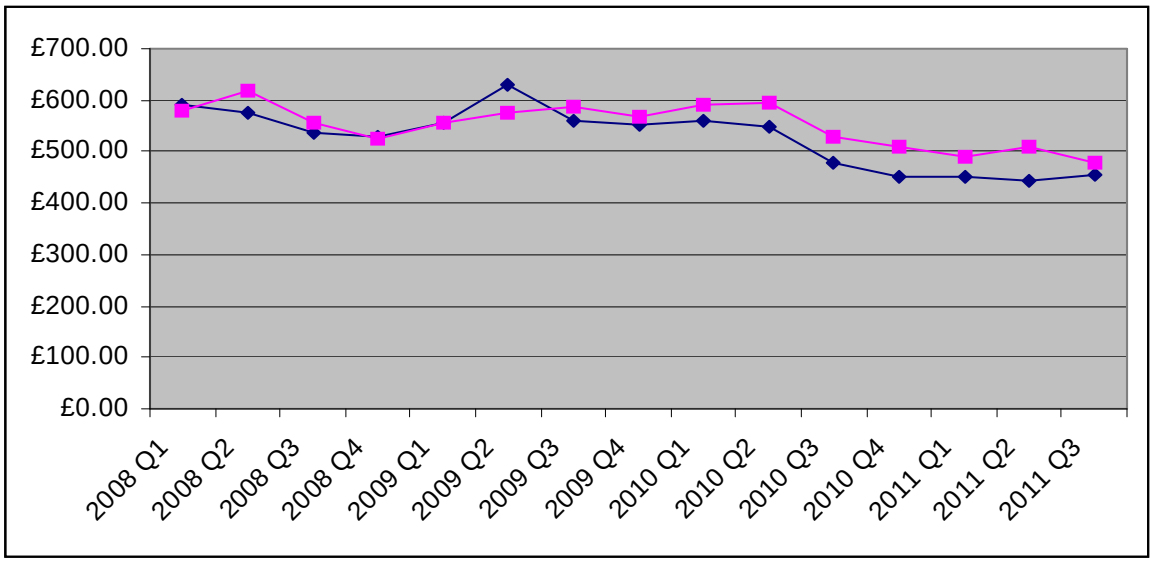
A large US study (Kripke DF, et al. Hypnotics' association with mortality or cancer: a matched cohort study. BMJ Open 2012;2:e000850 doi:10.1136/bmjopen-2012-000850) has suggested that patients who received hypnotic prescriptions had a significantly increased risk of dying over an average follow-up of 2.5 years, compared to those who didn't receive hypnotic prescriptions. A dose-response relationship was seen: the risk was increased around 3.6 times in patients who were prescribed fewer than 18 doses of hypnotic per year, and around 5.3 times in those prescribed more than 132 doses/year.

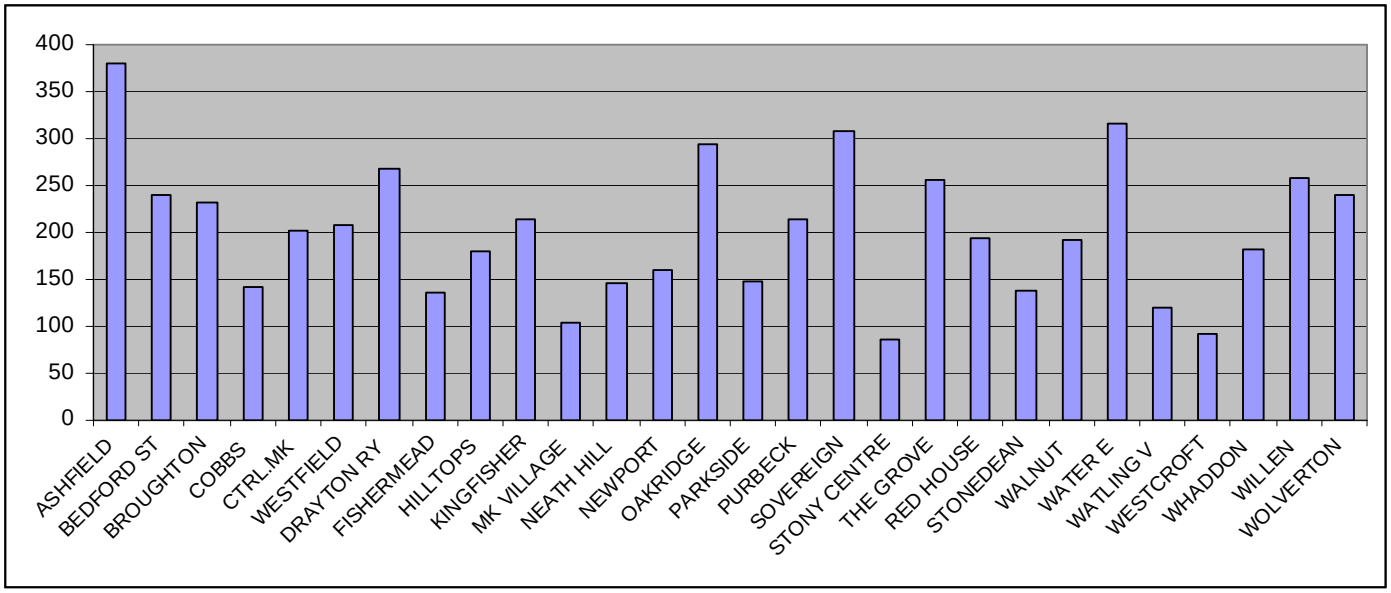
The study adds to the existing evidence about the harms of hypnotics and provides another reason to exercise caution when considering prescribing hypnotics, even when used according to national guidance (at low doses and for short periods of time). It also highlights the importance of reviewing patients who are already taking.

The Committee on Safety of Medicines advises that benzodiazepine hypnotics should be used only if insomnia is severe, disabling or causing the patient extreme distress. The lowest dose that controls symptoms should be used, for a maximum of **four weeks** and intermittently if possible. NICE guidance on zaleplon, zolpidem and zopiclone also recommends that when, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications. Patients who have been taking hypnotics long-term should be reviewed with the aim of reducing and stopping treatment.
Various approaches to reducing hypnotic prescribing can achieve significant success. The NPC has published some helpful information: see http://www.npc.nhs.uk/resources/personalising_medicines_management_web.pdf

A second study (M Uhart, E Odouard, C Carlier, P Maire, M Ducher, L Bourguignon**:** Annales Pharmaceutiques Francaises Jan 2012;70(1):46-52 reported the relationship between benzodiazepine use and falls in the elderly. It found that benzodiazepine consumption expressed in milligrams of diazepam-equivalent per hospitalisation day is significantly linked to the number of falls expressed during the same period (R = 0.63; p less than 0.01).

This graph shows benzodiazepine prescribing across the PCT (blue line) compared to the national average (pink line). It is good to see that the PCT average is now lower than the national average although there is wide variation across practices (lower graph).





Hayfever update
Drug Treatment options usually depend on which symptoms predominate and on whether topical or oral therapy is preferred.

Oral antihistamines reduce itching, sneezing and watery rhinorrhoea, but have little effect on nasal blockage. They also reduce eye and throat symptoms. They are effective when used 'as needed' but continuous use is optimal during the hayfever season. There is little to choose between them in terms of clinical effectiveness. Loratadine or Cetirizine are cost-effective first line options with generic fexofenadine as a second line agent when a non-sedating antihistamine is required. Chlorphenamine remains the sedating antihistamine of choice. If a liquid preparation is needed, Cetirizine 5mg/5ml oral solution is the first choice with loratadine syrup as another option.

Intranasal preparations relieve itching, sneezing and rhinorrhoea. They need to be used regularly and have a slower onset of action than oral antihistamines. It is best to start treatment at least a week before the anticipated start of the pollen season. The most cost-effective choice is beclometasone nasal spray – prescribed as branded Beconase. The script should state "200 dose" to avoid the more expensive 180 dose "Hayfever" OTC version being dispensed. The second line choice is fluticasone furoate (Avamys)

Intranasal sodium cromoglicate may be effective in prophylaxis of allergic rhinitis but is less effective than other standard drugs. Intranasal ipratropium bromide may help patients with prominent watery rhinorrhoea but has no effect on sneezing or nasal obstruction.

Anti-inflammatory eye drops
Sodium cromoglicate eye drops may be helpful for watery eyes but the evidence suggests a better effect with the oral antihistamines. The most economical pack size is 13.5ml.

Olopatadine Eye drops 1mg/ml should be reserved for those circumstances where treatment with sodium cromoglicate has failed. Treatment with olopatadine should be limited to a **maximum of 4 months**.

Other medicines
Oral corticosteroids should only be used in short courses for severe symptoms, unresponsive to other agents or to cover special events eg exams.

Intramuscular depot corticosteroid injection (Kenalog) is no longer recommended.

Over the counter products
A large range of antihistamines are available for purchase over the counter. They are generally inexpensive.

Summary of preferred products

Product	Adult dose	Cost / 28 days	Notes
Cetirizine	10mg OD	£1.05	1st choice oral antihistamine Prescribe generically
Loratadine	10mg OD	£1.16	Alternative 1st line antihistamine Prescribe generically
Fexofenadine	120mg OD	£2.60	Second line antihistamine Prescribe generically
Cetirizine oral solution 5mg/5ml	5 – 10mg OD	£1.83	Licensed for children 2 years upwards Prescribe generically
Beconase nasal spray	1 -2 puffs BD	£1.23 - £2.45	1st choice intranasal product Prescribe by Brand; 200 dose container
Fluticasone furoate	2 puffs OD reducing to 1 puff OD	£3.01 - £6.02	Second line intranasal preparation 120 dose container
Sodium cromoglicate eye drops 2%	QDS	£2.08	13.5ml container (OTC less expensive than prescription charge)

Safety information

Association of saxagliptin with serious hypersensitivity reactions and acute pancreatitis

Bristol-Myers Squibb and AstraZeneca have issued a letter to healthcare professionals regarding new safety information on the use of saxagliptin and the associated risk of serious hypersensitivity reactions and acute pancreatitis. The letter notes that a review of pharmacovigilance data identified several serious reports of angioedema and associated events and reports of anaphylactic reactions with saxagliptin use. There were also some reports of positive re-challenge. Therefore:

• Saxagliptin is now contra-indicated in patients with a history of serious hypersensitivity reactions, including anaphylactic reaction, anaphylactic shock, or angioedema, to saxagliptin, or any dipeptidyl peptidase 4 (DDP-4) inhibitor

• If a serious hypersensitivity reaction to saxagliptin is suspected, this treatment should be discontinued

A review of post-marketing reports of pancreatitis revealed that signs occurred after the start of saxagliptin treatment and resolved after discontinuation, suggesting a causal relationship. Moreover, pancreatitis has been recognised as an adverse effect of other DDP-4 inhibitors. Therefore:

• Patients should be informed of the characteristic symptom of acute pancreatitis; persistent, severe abdominal pain

• If pancreatitis is suspected, saxagliptin should be discontinued.

Snippets of information

- It's a good idea to record a review date for patients on a **bisphosphonate** to flag when they have been on the treatment for 10 years.
- **Nitrofurantoin** is sometimes being left on prescription for prophylaxis of urinary tract infection despite the patient having declining renal function. It should not be used if the eGFR is less than 60ml/minute/1.73m^2
- **Predfoam** brand of prednisolone rectal foam has been discontinued. Generic **Prednisolone 20mg** Application foam enema costs about **£48 for 14 applications**. Please consider prescribing **Colifoam** (Hydrocortisone Foam - £9.29 for 14 applications) where appropriate.
- **Omacor** recommended by NICE post MI within the lifestyle section. Trial data is weak so it is not good use of resources. Patients should be encouraged to eat a healthy diet that includes adequate amounts of oily fish.
- **Blood Glucose monitoring and driving**
  The local self monitoring of blood glucose guideline has been updated to incorporate a reminder about the DVLA requirements for drivers. The guidance is being circulated to practices.

RESPeRATE®

We have recently had a number of queries about prescription requests from patients for the RESPeRATE® device, which aims to reduce sympathetic activity by encouraging a reduced respiratory rate whilst the device is used. This in turn causes dilation of the arteries and a reduction in blood pressure.

According to NICE the device would fall within the group of lifestyle interventions classified as relaxation therapies. NICE Clinical Guideline on the management of primary hypertension has reviewed the evidence on the lifestyle interventions that help reduce blood pressure and concludes:

- *"The current evidence cannot determine whether a lifestyle intervention is generally better than drug treatment for reducing blood pressure"*.

It also states as a recommendation for lifestyle interventions:

- *"Relaxation therapies can reduce blood pressure and people may wish to pursue these as part of their treatment.* ***However, routine provision by primary care teams is not currently recommended****."*

The evidence base for this device is poor compared to the robust evidence for pharmacological therapies. The trials undertaken with this device were small (a total of 286 participants between the seven studies), of short duration (eight weeks) and not all were double-blinded and randomised (four were, one was controlled and randomised and two were open label). They reported a reduction in blood pressure, which is beneficial and is known to occur with other lifestyle measures too (such as healthy diet and exercise, reduction in sodium intake, stopping smoking and avoiding excess alcohol intake or caffeine containing products). The outcomes reported with this device are around the surrogate endpoint of reduced blood pressure with the epidemiological link to reduced rates of death and cardiovascular disease. They do not directly quantify significant changes in these patient oriented outcomes.

RESPeRATE® has recently been approved for addition to Part IXA of the Drug Tariff in February 2012 as *"Devices for adjunctive treatment of hypertension"*. **This means the device has not been approved for use alone and should only be considered in addition to optimal pharmacological therapy where this fails to adequately reduce the high blood pressure**. Although this device has been listed as available on the NHS, **there are no local prescribing recommendations for its use in Milton Keynes**. If this is something prescribers wish to consider for their patients, a formal submission to the Medicines and Therapeutics Committee will need to be made before it can be prescribed.

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744.