PRESCRIBING NEWS

NHS Milton Keynes

January 2010

Update from Prescribing Group, January 2010

- The group approved principles for therapeutic options for patients unable to take solid oral medicines (see below)
- The update process for ScriptSwitch was approved.
- Libby Pell, Specialist Dermatology Nurse and Naomi Fleming, Antibiotic Pharmacist presented guidance on the management of infected eczema which was ratified.
- The targets for next year's Prescribing Incentive Scheme were discussed. Details will be circulated once approved by PEC.

Orciprenaline Syrup (Alupent) is being discontinued as the MHRA has decided that risks of adverse cardiac reactions (tachycardia, palpitations) outweigh the benefits. Please review patients and change to a salbutamol inhaler if on-going treatment is required.
Vallergan Syrup is no longer available as a branded product. In the few cases where it is required, it should be prescribed as Alimemazine.

Update from Medicines and Therapeutics Committee, November 2009
Prasugrel was approved for addition to the formulary for use by cardiology in line with NICE Guidance which states that Prasugrel in combination with aspirin is recommended as an option for preventing atherothrombotic events in people with acute coronary syndromes having percutaneous coronary intervention, only when:

- immediate primary percutaneous coronary intervention for ST-segment-elevation myocardial infarction is necessary **or**
- stent thrombosis has occurred during clopidogrel treatment **or**
- the patient has diabetes mellitus.

The combination is normally used for up to 12 months. For hospital initiation only. As with clopidogrel, add a note of the stop date to the patient record.
Versatis (lidocaine patches) have **not** yet been approved for inclusion in the formulary.

Therapeutic options for patients unable to take solid oral dosage forms.
Some patients are unable to take medication in solid oral dosage forms. A stepwise approach is suggested to choose a suitable alternative:

1. If possible, use a licensed medicine in a suitable formulation to meet the patient's needs (e.g. a dispersible tablet or licensed liquid medicine).
2. If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner, for example by crushing tablets or opening capsules
3. In order to use a licensed medicine, consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.
4. In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order products ('specials') may be considered.

- Licensed medicines should be used where possible. They are manufactured to specific standards and have been assessed for safety and efficacy.
- Special-order products are unlicensed and are not required to meet the same standards as licensed preparations. Prescribers assume greater liability when using them. They are considerably more expensive than licensed medicines.
- Please contact your Practice Pharmacist / Technician or the Pharmaceutical Advisers for advice about individual medicines. See attached insert with a list of common special order medicines that are being prescribed in MK.

Prescribing ciclosporin
The MHRA has issued advice to prescribers to ensure the safe prescribing and dispensing of ciclosporin. Ciclosporin is a critical-dose drug with a narrow therapeutic index. Patients should be stabilised on a single brand of ciclosporin because switching between formulations without close monitoring may lead to clinically important changes in blood levels. All products that contain ciclosporin are interchangeable **only** if careful therapeutic monitoring takes place. Prescribing and dispensing of ciclosporin should be by brand name to avoid inadvertent switching.

The established brands are Neoral (available as an oral solution or as soft gelatine capsules) and Sandimmun (available as an oral solution, concentrate for infusion or soft gelatine capsules). In line with advice from the British National Formulary, oral versions of Sandimmun are only prescribable on a named-patient basis for those who cannot be transferred to another brand of ciclosporin.

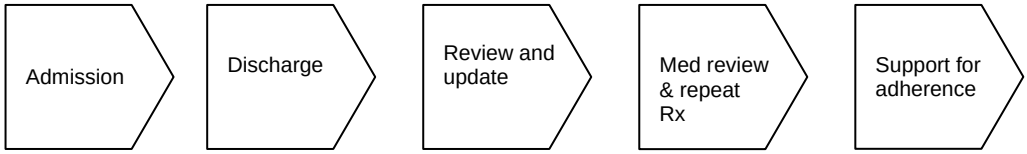
Most patients will be under the care of specialist services. Please follow any advice that they give you with regard to brand names.

Managing patients' medicines after discharge from hospital
CQC Report, October 2009

Background

A large proportion of the UK population is taking a medicine, and the number of medications prescribed is increasing. Managing medicines when a patient is transferred from one setting to another is central to safe, high-quality care. It is also an area where considerable efficiencies could be made, by reducing avoidable hospital admissions.

A study carried out by the Care Quality Commission looked at what organisations were doing to ensure the safety of patients who had been discharged from hospital with a change of medication, along the key steps of the pathway in this process:



The report sets out findings from visits to 12 primary care trusts (PCTs) – including a survey of their GP practices, analysis of national datasets, and research exploring the experience of patients. In general, CQC found that there were good systems in place to ensure the safety of repeat prescribing, and to ensure that reviews of medication for high-risk patients took place after their discharge from hospital. However, their study raised concerns about a number of areas in the medicines management process that occur between general practices and hospitals.

The report makes a number of recommendations to ensure that the information flows into and out of hospital are robust and reliable. These include:-

- Health communities should agree the use of standard referral forms, including a specification for the information that GPs will provide to local acute trusts when a patient is admitted, taking account of the guidance from the National Prescribing Centre. This should cover elective and emergency admissions, and set out timeframes for the provision of this information. They should then audit the use of this form.
- PCTs should work with GPs to clarify their expectations of GP practices, in relation to reconciliation, medication review and repeat prescribing. These should be in line with national guidance and cover the quality of processes (for example, the elements of medication review that are completed) as well as their timeliness.
- PCTs should make better use of the information they already have on the performance of their GPs in relation to medicines management.
- GPs should ensure that they carry out a higher proportion of medication reviews with the patient present, so that they can discuss the patient's experience of taking the medicines.

Admission and Discharge

The following information **should be supplied by the GP** when a patient goes into hospital	The **GP should expect to receive** a discharge summary containing the following information
* Complete patient details * Presenting condition and co-morbidities * A list of all medicines currently prescribed for the patient (including OTC medicines if known) * Dose, frequency, formulation, route of all medicines * Known allergies * Major side effects / sensitivities / adverse reactions to previously taken medicines	***** Key diagnosis made during patient's admission * Prescribed medication, current at time of discharge with relevant stop dates * Any adverse reactions or allergies documented during admission * The name of the responsible Consultant * Any immediate post discharge requirement for the primary healthcare team * Any planned follow up arrangements * Whether the patient has any relevant infection * Who should be contacted in the event of a query

Review and update
Practices should ensure that there is a policy in place to manage the flow of discharge information and ensure that if someone other than the GP makes changes to medication records, they are suitably experienced and prescriptions cannot be issued without a check by the doctor. The main risk of error is adding a medicine but not discontinuing the one it replaces.

Medication review and repeat prescribing
The review of medicines and generation of repeat prescriptions should include an assessment of continuing need for the medication and any monitoring associated with the use of the drug or the condition for which it is being prescribed. The review should address all medicines at the same time rather than looking for example at diabetic drugs at one review and drugs for CHD at another time. It should be carried out by a doctor, nurse prescriber or pharmacist.

Ideally a medication review should be conducted with the patient present as this allows a more thorough review of side effects, compliance etc. This is not always possible - at minimum, the review should be carried out with access to the patient's medical records.

Support for adherence
After returning home, patients do not always take their medicines as prescribed. It is therefore important that regimens are simplified and the patients are given information about their treatment and the importance of taking it correctly.

Summary
It is essential that there are good systems in place to ensure the accuracy of information about medicines being transferred between primary and secondary care in order to ensure patient safety. Please contact the Pharmaceutical Advisers if you would like further information or help.

New flu vaccine
Please be aware that Sanofi are promoting a new intradermal influenza vaccine for the 2010-11 season on the basis of improved seroconversion rates. However, the European Medicines Agency has stated that the clinical relevance of any difference in seroconversion rates is questionable. There also appears to be higher incidence of injection site reactions with ID than IM use. Furthermore, the cost to the NHS is 50% more than the current vaccines. The new vaccine is not included in the Green Book. The Pharmaceutical Advisers do not support its use.

Go Generic …… or use the brand name?
The Pharmaceutical Advisers have consistently promoted the “go generic” message to ensure prescriptions are written in the most cost effective manner. Occasionally, because of the complexity of medicines pricing, a brand is less expensive than its generic equivalent. We have made the decision to only recommend the use of a brand name in the few instances where significant savings can be made. If clinicians in Milton Keynes prescribe salbutamol inhalers as Ventolin, savings in excess of £100k would be made. Many pharmacies already dispense Ventolin against a salbutamol prescription so the patient may not see a change in the inhaler that they receive.

Lithium
The NPSA has issued a safety alert on lithium. Matt Elswood, Specialist Pharmacist in Mental Health is leading on the work across primary and secondary care. Please look out for advice over the next few months. In the meantime, the Pharmaceutical Advisers have noted that quite a lot of lithium is not being prescribed by brand name as recommended by the BNF.
The bioavailability of lithium preparations varies widely. Priadel is the most widely used branded preparation in Milton Keynes.
Please review your lithium prescriptions, check with the patient which brand they are using and prescribe by brand.

ScriptSwitch goes live!
The Milton Keynes version of ScriptSwitch has gone live. We have taken notice of comments made to refine the wording in some of the information boxes and welcome further feedback as prescribers become more familiar with the system. Updates will be made monthly.

Please note that ScriptSwitch should only be installed on computers used by clinical staff (GPs, nurse prescribers and the practice pharmacists and technicians). The decision to change items on the prescription **must** be made by a clinician.

Sibutramine has been withdrawn
The MHRA has suspended the license for **sibutramine (Reductil)** because they feel the benefits are outweighed by the cardiovascular risks. People who are currently taking sibutramine are advised to make a routine appointment with their doctor to discuss alternative measures to lose weight. There are no health implications if people wish to stop treatment before seeing their doctor.

Is the use of lower-price statins linked to poorer cholesterol control?

A study published in the : **British Journal of General Practice 2010; 60: 50-2** suggested that practices that have a greater proportion of low-cost statin prescribing may have poorer control of cholesterol levels. However, it should be noted that the study should not be over interpreted and cannot be used to show that use of the lower-cost statins will automatically lead to poorer clinical outcomes. Limitations that dictate caution include the lack of dose information in the data used, lack of epidemiological data, and the use of a surrogate measure (total cholesterol) as the outcome. The prescribing data did not show a normal distribution, with most practices clustering around the median and few prescribing less than 55% low-cost statins. Finally, there is a conflict of interest: the author is a member of a dispensing practice with a low proportion of low-cost statin prescribing (48.6% for the study period). **National and local policy remains to prescribe simvastatin 40mg as the first line choice in both primary and secondary prevention. The choice is supported by a solid evidence base**.

Changes to statin side effect warnings

Product information for statins is being updated to include a number of adverse reactions, as required by the MHRA.

Summaries of product characteristics and patient information leaflets for statins will be amended to include interstitial lung disease as a side effect. Patients with symptoms of interstitial lung disease, such as dyspnoea, non-productive cough and general deterioration in health should be advised to seek medical advice.

Other side effects to be added to the list, and ones that patients should be made aware of, are depression, sleep disturbances, memory loss and sexual dysfunction.

Colchicine quantities

Colchicine is very toxic in overdose and its management is complex. If colchicine is being prescribed for acute gout, please restrict the quantity prescribed to a maximum of 12 tablets as 6mg is the maximum recommended dose.

The Risks of Combining Tramadol with Antidepressants

Tramadol is known to cause serotonin syndrome particularly when it is used at high doses or in combination with other medicines which increase serotonergic neurotransmission. The manufacturer of tramadol states that *co-administration with serotonergic drugs, e.g. SSRIs, triptans or with monoamine oxidase inhibitors may lead to an increase of serotonin-associated effects, which can include serotonin syndrome*.

Serotonin syndrome occurs as a result of excessive serotonergic neurotransmission and produces a spectrum of clinical findings from barely perceptible to lethal in severity. Patients with mild manifestations may present with sub-acute or chronic symptoms, whereas severe cases may progress rapidly leading to death.

Serotonin syndrome is characterised by three groups of symptoms:

1. Neuromuscular hyperactivity – hyperreflexia, clonus, myoclonus, tremor and rigidity;
2. Autonomic hyperactivity – hyperreflexia, tachycardia and diaphoresis;
3. Altered mental-state - agitation, anxiety, hypomania and confusion.

Symptoms usually occur following changes in therapy or increases in dose of a concomitant drug that can increase serotonin levels. Other potential causes such as infections, metabolic disturbances, substance abuse, or withdrawal need to be excluded. Differential diagnoses include malignant hyperthermia, anticholinergic poisoning and neuromuscular malignant syndrome.

Please therefore try to avoid the combination of tramadol with SSRIs or triptans.

Tramadol and the Elderly

A study to assess the appropriateness of prescriptions for tramadol hydrochloride and associated adverse effects in patients over 65 years showed that although tramadol is an effective agent for treating mild to moderate pain it is associated with a range of adverse effects which have the potential to cause significant morbidity.

There is no evidence to suggest that tramadol is any more effective than other weak opioids in the management of pain and, when considering the adverse effect profile and added cost of prescribing in comparison with other analgesics, its place in therapy is questionable.

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278708 / 278744 / 278702.