PRESCRIBING NEWS

NHS Milton Keynes

July 2010 V2

Update from Prescribing Group, July 2010

- Prescribing Group discussed how the Outpatient letter could be improved to ensure Consultants passed on important information about medicines to GPs when asking them to prescribe. We hope to have a new version ready in the autumn.
- The final data from the 2009-10 Prescribing Incentive Scheme was reviewed. Congratulations to the 24 practices that have achieved targets.
- It was noted that there are supply problems with ezetimibe and risedronate. However, neither are preferred choices for most patients.

Update from Medicines and Therapeutics Committee, June 2010

- Decisions on adding lidocaine patches and high dose calciferol tablets to the formulary were deferred until additional guidance has been developed. For now, lidocaine patches remain non-formulary and calciferol is only on the formulary for secondary care prescribing.
- MK Traffic Light System was approved – see below for more details.

MK Traffic Lights

This list has been developed to clarify where it is most appropriate for prescribing responsibility to lie. The list will be kept under review by Medicines and Therapeutics Committee. ScriptSwitch will be used to alert GPs to medicines that should be prescribed by a Specialist. The colour codes are:-

Black – Not recommended for use or waiting for consideration of formulary status.

Brown – Prescribe only in restricted circumstances

Red List – Specialist Prescribing Only

Yellow - Transfer of prescribing to primary care in line with Shared Care Protocol or following specialist recommendation as indicated

Green - All other formulary medicines.

The list can be found on the PCT medicines pages of the intranet and will shortly be available on the hospital intranet site in the Formulary section.

Cardiovascular risk of NSAIDs in a healthy population: cohort study

Reference: **Circulation: Cardiovascular Quality and Outcomes, published online June 8, 2010**

According to the results of a population-based historic cohort study conducted in Denmark, individual NSAIDs have different degrees of cardiovascular safety in a healthy population, which must be considered when choosing appropriate treatment. The authors note that previous studies have raised concern about the cardiovascular safety of NSAIDs; the majority of the evidence however comes from trials performed in populations with an increased cardiovascular risk or established disease, or those evaluating a non-cardiovascular endpoint. The aim of the study was to investigate the cardiovascular risk associated with NSAIDs in healthy individuals, using a nationwide cohort.

The risk of cardiovascular death, a composite of coronary death or non-fatal myocardial infarction, and fatal or nonfatal stroke associated with the use of NSAIDs was estimated by case-crossover and Cox proportional hazard analyses.

The study population consisted of 1,028,427 apparently healthy individuals with a median age of 39 years. At least one prescription of an NSAID was claimed by 44.7% of the study population from 1997 to 2005. During the study period, 56,305 individuals died, of whom 2204 died during treatment with an NSAID. Some of the key findings included the following:

- An increased risk of cardiovascular death was seen with use of diclofenac (odds ratio [OR] 1.91; 95% CI 1.62 to 2.42) and rofecoxib (OR 1.66; 95% CI 1.06 to 2.59), with a dose-dependent increase in risk.
- Naproxen was not associated with increased cardiovascular risk (OR for cardiovascular death, 0.84; 95% CI 0.50 to 1.42).

This study found most NSAIDs are associated with increased cardiovascular mortality and morbidity; in particular the use of diclofenac and rofecoxib was associated with a similarly increased risk among healthy individuals. Naproxen may be a safer alternative when NSAID treatment is required, but physicians should always make an individual assessment of cardiovascular risk and balance the benefit and risk before starting treatment with any NSAID."

The % NSAIDs prescribed as diclofenac in Milton Keynes has fallen from 47% in 2009 to 38% in 2010. This is excellent progress towards improving patient safety. Well Done!

Aspirin with or without an antiemetic for acute migraine headaches in adults
Reference: **Kirthi V, Derry S, Moore RA, McQuay HJ. Cochrane Database of Systematic Reviews 2010, Issue 4.**

The current Prescribing Incentive Scheme encourages practices to review triptan prescribing. But are triptans always necessary for migraine? A recent Cochrane Review looked at aspirin versus other comparators – mainly sumatriptan.

Thirteen studies (4222 participants) compared aspirin 900mg or 1000mg, alone or in combination with metoclopramide 10 mg, with placebo or other active comparators, mainly sumatriptan 50mg or 100mg. For all efficacy outcomes, all active treatments were superior to placebo. For aspirin alone versus placebo, the NNTs were 8.1, 4.9 and 6.6 for 2-hour pain-free, 2-hour headache relief, and 24-hour headache relief respectively compared to 8.8, 3.3 and 6.2 for aspirin plus metoclopramide versus placebo. Sumatriptan 50mg did not differ from aspirin alone for 2-hour pain-free and headache relief, while sumatriptan 100 mg was better than the combination of aspirin plus metoclopramide for 2-hour pain-free, but not headache relief; there were no data for 24-hour headache relief.

Associated symptoms of nausea, vomiting, photophobia and phonophobia were reduced with aspirin compared with placebo, with additional metoclopramide significantly reducing nausea ($P < 0.00006$) and vomiting ($P = 0.002$) compared with aspirin alone. Fewer participants needed rescue medication with aspirin than with placebo. Adverse events were mostly mild and transient, occurring slightly more often with aspirin than placebo.

Authors' conclusions
Aspirin 1000mg is an effective treatment for acute migraine headaches, similar to sumatriptan 50mg or 100mg. Addition of metoclopramide 10mg improves relief of nausea and vomiting. Adverse events were mainly mild and transient, and were slightly more common with aspirin than placebo, but less common than with sumatriptan 100mg.

The results of the review were picked up by some national papers so patients may already know about the effectiveness of aspirin. It may be worth trying aspirin as a first line alternative to triptans.

The NICE Guideline on COPD 2010.
The guideline now states that people with stable COPD who remain breathless or have exacerbations despite using short-acting bronchodilators as required, should be offered the following as maintenance therapy:

- **if $FEV_1 \geq 50\%$ predicted**: either long-acting $beta_2$ agonist (LABA) eg salmeterol or long-acting muscarinic antagonist (LAMA) eg tiotropium
- **if $FEV_1 < 50\%$ predicted**: either LABA with an inhaled corticosteroid (ICS) in a combination inhaler, or LAMA.

In people with stable COPD and an $FEV_1 \geq 50\%$ who remain breathless or have exacerbations despite maintenance therapy with a LABA:

- consider LABA+ICS in a combination inhaler
- consider LAMA in addition to LABA where ICS is declined or not tolerated.
- Offer LAMA in addition to LABA+ICS to people with COPD who remain breathless or have exacerbations despite taking LABA+ICS, irrespective of their FEV_1. Consider LABA+ICS in a combination inhaler in addition to LAMA for people with stable COPD who remain breathless or have exacerbations despite maintenance therapy with LAMA irrespective of their FEV_1.

The choice of drug(s) should take into account the person's symptomatic response and preference, and the potential to reduce exacerbations, side effects and cost.

Please check inhaler technique before stepping up treatment. Many patients have difficulty with their devices.

The guideline also notes that prescribers should be aware of the potential risk of developing side effects (including non-fatal pneumonia) in people with COPD treated with inhaled corticosteroids and be prepared to discuss this with patients.

ScriptSwitch update!
The savings from ScriptSwitch for the first 6 months of use stand at £179k out of a possible £814k. A total of 16,107 switches have been accepted. Of these, 11,635 are for acute prescriptions and 4,472 are for repeat medicines.

The top four most frequently accepted changes are:-

- Salbutamol inhaler to Ventolin inhaler
- Ferrous sulphate 200mg tablets to ferrous fumarate 210mg tablets
- Beclometasone nasal spray to Beconase nasal spray
- Diclofenac 50mg to naproxen 500mg

Do you know pregabalin's side effect profile?

Very Common (> 1/10)
Dizziness, somnolence

Common (> 1/100, < 1/10)
Euphoric mood, confusion, irritability, libido decreased, disorientation, insomnia, ataxia, coordination abnormal, tremor, dysarthria, memory impairment, disturbance in attention, paraesthesia, sedation, balance disorder, lethargy, vision blurred, diplopia, vertigo, vomiting, dry mouth, constipation, flatulence, erectile dysfunction ,gait abnormal, feeling drunk, fatigue, oedema peripheral, oedema, weight increased

Uncommon (>1/1000, <1/100)
back pain, pain in limb, muscle stiffness, nasopharyngitis, syncope, stupor, myoclonus, psychomotor hyperactivity, ageusia, dyskinesia, dizziness postural, intention tremor, nystagmus, cognitive disorder, speech disorder, hyporeflexia, hypoaesthesia, amnesia, hyperaesthesia, burning sensation, anorexia, hypoglycaemia hallucination, panic attack, restlessness, agitation, depression, depressed mood, mood swings, depersonalisation, word finding difficulty, abnormal dreams, libido increased, anorgasmia, apathy, visual disturbance, eye swelling, visual field defect, visual acuity reduced, eye pain, asthenopia, dry eye, lacrimation increased, hyperacusis, tachycardia, atrioventricular block first degree flushing, hot flushes, hypotension, hypertension, dyspnoea, nasal dryness, abdominal distension, gastrooesophageal reflux disease, salivary hypersecretion, hypoaesthesia oral rash papular, sweating ,muscle twitching, joint swelling, muscle cramp, myalgia, arthralgia, urinary incontinence, dysuria ejaculation delayed, sexual dysfunction, falls, chest tightness, asthenia, thirst, pain, feeling abnormal, chills

Rare(<1/1000)).
neck pain, cervical spasm, neutropenia, disinhibition, elevated mood, hypokinesia, parosmia, dysgraphia, peripheral vision loss, oscillopsia, altered visual depth perception, photopsia, eye irritation, mydriasis, strabismus, visual brightness, sinus tachycardia, sinus arrhythmia, sinus bradycardia ,peripheral coldness, epistaxis, throat tightness, nasopharyngitis, cough, nasal congestion, rhinitis, snoring, ascites, pancreatitis, dysphagia, urticaria, cold sweat, rhabdomyolysis, renal failure, oliguria, amenorrhoea, breast discharge, breast pain, dysmenorrhoea, hypertrophy breast, anasarca, pyrexia,

Frequency not known
Hypersensitivity, angioedema, allergic reaction, aggression, loss of consciousness, mental impairment, headache, malaise, vision loss, keratitis, congestive heart failure, QT prolongation, swollen tongue, diarrhoea, nausea Stevens Johnson syndrome, pruritus ,urinary retention, face oedema

Pregabalin is not on the formulary, has an extensive range of potential side effects and cost NHSMK over £200k last year. Was this good value?

NHS Prescriptions for patients going abroad
At present the BMA recommend that doctors prescribe **no more than three months supply** of medicines for patients not in the country, as per the current regulations, stating:

"The NHS accepts responsibility for supplying ongoing medication for temporary periods abroad of up to 3 months. If a person is going to be abroad for more than three months then all that the patient is entitled to at NHS expense is a sufficient supply of his/her regular medication to get to the destination and find an alternative supply of that medication".[1]

[1] Information and guidance on prescribing in general practice, Guidance for GPs, BMA September 2004

Study evaluates possible interaction between influenza vaccination and warfarin treatment
The flu vaccination season is approaching again. Each year we are asked about possible interactions between the vaccination and warfarin.

According to research published in the Archives of Internal Medicine, influenza vaccination has no significant effect on INR values or warfarin weekly doses. Furthermore, close monitoring of INR values is not required after influenza vaccination in patients on stable long-term warfarin.

In this placebo-controlled, randomised, double-blind crossover study, researchers evaluated the variation in the INR, and warfarin weekly dose variation after influenza vaccination administration and followed patients up for related haemorrhagic and thrombotic events, to evaluate the safety of the influenza vaccine and to assess the immunogenicity of the influenza vaccination in patients receiving warfarin.

The researchers reported that the percentages of time that patients were in therapeutic range were 70.7% after receiving vaccine and 72.4% after receiving placebo (P = 0.57). There were no reports of fatal or major bleeding events, and 11 minor mucocutaneous haemorrhagic events. Furthermore in terms of response to vaccination, the percentage of seroprotected patients ranged from 92.0% to 100.0% for all patients, depending on the vaccine antigen examined.

These results are re-assuring.

Opportunities to reduce prescribing costs
You will be aware that the PCT has to make substantial savings this year. The prescribing budget is coming under close scrutiny. There will have to be difficult decisions made about services and staff so it is important that money is not wasted on prescriptions for expensive medicines when an alternative product is clinically effective but cheaper or self care is possible.

The Pharmaceutical Advisers have discussed these areas with prescribers in the past. Please contact your Practice Pharmacist, Medicines Management Technician or one of the Pharmaceutical Advisers if you require any further information.

Therapy area	Comments
Analgesic patches – Fentanyl, lidocaine	Oral morphine is acceptable (and safer) alternative unless patient is nil by mouth. Please remember the conversion – fentanyl patch 25mcg is equivalent to morphine 90mg per day. Opioid naïve patients should not be given fentanyl patches.
Gluten free foods	Please remember that a wide range of gluten free foods are available in supermarkets now - restrict prescriptions to basic foods. Quantities as per guidance previously issued.
Sip feeds in care homes	Food First! Should be possible for care homes to provide adequate nutrition for their residents – sip feeds are a convenient but costly answer
Drugs of limited clinical value / marked as “less suitable for prescribing” in the BNF	Could be purchased over the counter; use medicines that are supported by a sound evidence base
Drugs for erectile dysfunction	Most already issued on private prescription but significant amount prescribed locally for indications allowed under NHS regulations; please restrict quantities to **4 tablets** per month and refer non-schedule 11 indications back to the hospital eg “Severe distress”
Treatment for obesity	Please use in line with NICE guidance http://www.nice.org.uk/nicemedia/live/11000/30364/30364.pdf Ensure patients are compliant and weight is regularly reviewed.
Pregabalin	Widely used by Pain Clinic but non-formulary; cheaper alternative is gabapentin capsules.
Dementia medicines	Restrict use in line with NICE Guidance http://www.nice.org.uk/nicemedia/live/10998/30317/30317.pdf
Analogue insulin	Restrict use in line with NICE Guidance http://www.nice.org.uk/nicemedia/live/11983/40803/40803.pdf
Paracetamol capsules	Tablets less expensive
Antacids	Could be purchased over the counter
Contraceptive patches and expensive formulations	Oral “pills” should be used first line Evra Patch and Cerazette are only for use where there are concerns over compliance Yasmin, Qlaira have not been approved for use in MK
Coxibs	No advantage over conventional NSAIDs
Haemorrhoid preparations	Could be purchased over the counter – or, if prescribing, please follow product choice on ScriptSwitch
Antihistamines	Could be purchased over the counter; avoid repeats if seasonal
Omega 3 products	Not supported by good evidence; patients should be encouraged to adopt a healthy diet including oily fish
Antimalarials and travel vaccines	Should only be prescribed on private prescription

The Department of Health is due to publish a list of about 30 therapeutic areas where it expects savings to be made. Please look out for further information in the next few weeks.

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