Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

June 2013

CCG Prescribing Group Meeting – 1st May 2013

A range of topics were discussed including:-

- The Prescribing Incentive Scheme for 2013-14
- "Just in case" boxes for symptom control at the end of life. Please look out for information on the new scheme which will be launched shortly.
- COPD rescue packs – again more information coming soon.
- PGD for the supply of emergency hormonal contraception by community pharmacists. The PGD now allows supply to women up to the age of 25 years (formerly the age limit was 19 years)
- Fosfomycin is an antibiotic for use in UTI ESBLs following a culture result. The laboratory is starting to report this as a possible antibiotic. Please note that it is unlicensed and will have to be ordered in specially. Community pharmacies will be issued with two starter packs for convenience of patients.

Milton Keynes Prescribing Advisory Group (MKPAG) – 10th April 2013 and 29th May 2013

The first two meetings of the newly formed Milton Keynes Prescribing Advisory Group were held at Milton Keynes Hospital on 10th April and 29th May.
MKPAG replaces the old Medicines and Therapeutics Committee. Dr Nigel Fagan remains on the group to represent MK GPs.

Levetiracetam was added to the formulary for use in line with NICE guidance

Therabite was added to the formulary for specialist prescription only. GPs should refer back any requests to prescribe it.

Ulipristal (Esmya) was referred back to the Specialist for more information so as yet it is not approved for use.

Valaciclovir was added to the formulary as a second line option for people who would have compliance problems with aciclovir. Please do not use famciclovir as it is much more expensive.

Gluten Free Policy

The Gluten Free policy has been updated with the addition of oats and breakfast cereal as allowed items. Please be aware that, in line with healthy living guidelines, gluten free cakes, cake mixes and sweet biscuits should **NOT** be prescribed. The guidance can be found on the formulary website.

Additionally, Gluten free products should **NOT** be prescribed in situations where the patient does not meet the ACBS criteria i.e. the patient should have a diagnosis of Coeliac disease or Dermatitis Herpetiformis or steatorrhoea due to gluten sensitivity

All prescriptions should be clearly marked ACBS and supply should be limited to **28 days** at a time for all patients.

Name changes

Please be aware that the BNF and British Pharmacopoeia have amended the spelling of sulphate to sulfate for all products containing sulfate (or sulfur containing compounds e.g. sulfonate). For example ferrous sulphate is now ferrous sulfate.

Useful leaflets

The Self Care Forum website contains useful evidence based patient self-help sheets for low back pain, eczema, heartburn and indigestion, fever in children, constipation, headache and migraine, cough, acne, sprains and strains and sore throat.

The Fact Sheets are free to download from the Self Care Forum website and may be reproduced, copied, printed and distributed without further permission. If however, the content is altered permission would need to be sought.

Self-Care Week 2013 will take place from 18th – 24th November 2013 so practices may wish to print some of the resources and display them in the waiting room.

http://www.selfcareforum.org/fact-sheets/

Strontium safety warning – Risk of serious cardiac disorders

A review of available safety data for strontium ranelate (Protelos) has raised concern about its cardiovascular safety beyond the already recognised risk of venous thromboembolism. An analysis of randomised controlled trial data has identified an increased risk of serious cardiac disorders, including myocardial infarction (relative risk compared with placebo was 1.6 [95% CI 1.07–2.38]).

The European Medicines Agency will fully evaluate the benefits and risks of strontium ranelate in the coming months. In the meantime, in order to help minimise these risks, their advice to healthcare professionals is:-

- Use of strontium ranelate is now restricted to treatment of severe osteoporosis
  - in postmenopausal women at high risk of fracture
  - in men at increased risk of fracture
- Treatment should only be initiated by a physician with experience in the treatment of osteoporosis, and the decision to prescribe strontium ranelate should be based on an assessment of the individual patient's overall risks
- Strontium ranelate should not be used in patients with: ischaemic heart disease, peripheral arterial disease; cerebrovascular disease; a history of these conditions; or in patients with uncontrolled hypertension
- Prescribers are advised to assess the patient's risk of developing cardiovascular disease before starting treatment and thereafter at regular intervals
- Patients with significant risk factors for cardiovascular events (eg, hypertension, hyperlipidaemia, diabetes mellitus, smoking) should only be treated with strontium ranelate after careful consideration
- Treatment should be stopped if the patient develops ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, or if hypertension is uncontrolled
- Healthcare professionals should review patients at a routine appointment and consider whether or not to continue treatment

Suspected adverse reactions to strontium ranelate should be reported to the MHRA on a Yellow Card

Drug name confusion

The MHRA has recently been made aware of medication errors resulting from patients being prescribed or supplied with the wrong medicine from the list below, owing to confusion between similarly named products.

Prescribers and dispensers should take particular care when prescribing or dispensing these medicines because their names could be confused with each other (i.e. they sound alike or look alike).
Recent examples of medicine names that have been confused resulting in medication errors include:

- Mercaptamine and mercaptopurine
- Sulfadiazine and sulfasalazine
- Risperidone and ropinirole
- Zuclopenthixol decanoate and zuclopenthixol acetate

Some of these errors could result in life-threatening conditions. The MHRA previously issued a reminder to remain vigilant when prescribing mercaptamine or mercaptopurine after a case of a 9-month-old who was erroneously prescribed mercaptopurine instead of mercaptamine by their GP. After approximately 1 month of incorrect treatment, the child was admitted to hospital with pancytopenia; the child fortunately made a full recovery.

Adrenaline pens – Quantity to issue?

We are sometimes asked for guidance on what is a reasonable number of adrenaline / epinephrine pens to prescribe for a child. The guidance is that the child should have 2 injectors available in each setting where they regularly spend time e.g. home, school or child minder. This means many children will require up to 6 to avoid having to remember to take the injector from one setting to the next.

Alterations to Medication Administration Recording Sheets (MARS)

Michael Ramsden, District Nursing Manager, has asked us to bring to your attention an incident where a GP updated a MARS form for the carers to assist the patient to take medication. Although this may seem acceptable practice, the information added was confusing and ended up with the patient receiving an increased dose of metformin. Fortunately, the patient was fine with no effects.

The District Nursing Managers have asked that GPs refer any patient needing amendments to a MARS chart to the DN service.

Updated information on opioid equivalence

BNF 65 contains a new table setting out approximate equivalent doses of opioid analgesics although it adds a caution that patients should be closely monitored after any change in medication as dose titration may be required.

Analgesic	Route	Dose
Codeine	PO	100mg
Diamorphine	IM, IV, SC	3mg
Dihydrocodeine	PO	100mg
Hydromorphone	PO	2mg
Morphine	PO	10mg
Morphine	IM, IV, SC	5mg
Oxycodone	PO	6.6mg
Tramadol	PO	100mg
PO by mouth; IM intramuscular; IV intravenous: SC subcutaneous		

The Pharmaceutical Advisers continue to be concerned about the high levels of prescribing of fentanyl and tramadol in Milton Keynes. As a reminder, approximately equivalent doses between 24-hour doses of oral morphine and 72 hour fentanyl patches are:-

Fentanyl 12 patch	Morphine 30mg daily
Fentanyl 25 patch	Morphine 60mg daily
Fentanyl 50 patch	Morphine 120mg daily
Fentanyl 75 patch	Morphine 180mg daily
Fentanyl 100 patch	Morphine 240mg daily

Value of Z drugs?

A meta-analysis has investigated the effectiveness of Z drugs for insomnia using published and unpublished RCTs submitted to the US FDA for regulatory approval (Huedo-Medina et al. 2012). The study included 13 RCTs (n=4,378) comparing a Z drug with placebo for the treatment of primary insomnia.

The meta-analysis found that both Z drugs and placebo statistically significantly reduced sleep latency. The reductions in subjective sleep latency seen with Z drugs and placebo were 25 minutes (95% CI 20 to 30 minutes) and 19 minutes (95% CI 12 to 27 minutes), respectively. This difference was not significant.

Sleep duration is an important outcome for people with insomnia. In these studies this outcome was infrequently reported and was a secondary outcome. Analysis of the secondary study outcomes showed no significant effect of Z drugs.

When considering prescribing a Z drug it is necessary to balance this relatively small benefit with the well documented risk profile of these agents. The relatively large placebo response adds strength to the argument to prioritise non drug and specifically psychological interventions.

The authors commented that "It is appropriate to continue to follow current guidance for the management of insomnia: to consider Z drugs when first-line non drug interventions are unsuccessful or inappropriate; to prescribe them for short periods (usually up to 2 to 4 weeks only) at the lowest effective dose; and to avoid repeat prescribing.

A consensus statement on addiction to medicines was published by the Royal College of General Practitioners and the Royal College of Psychiatrists. It sets out how medical practitioners, specialist services and patients can work together to improve responses for people dependent on prescribed or over-the-counter medicines.

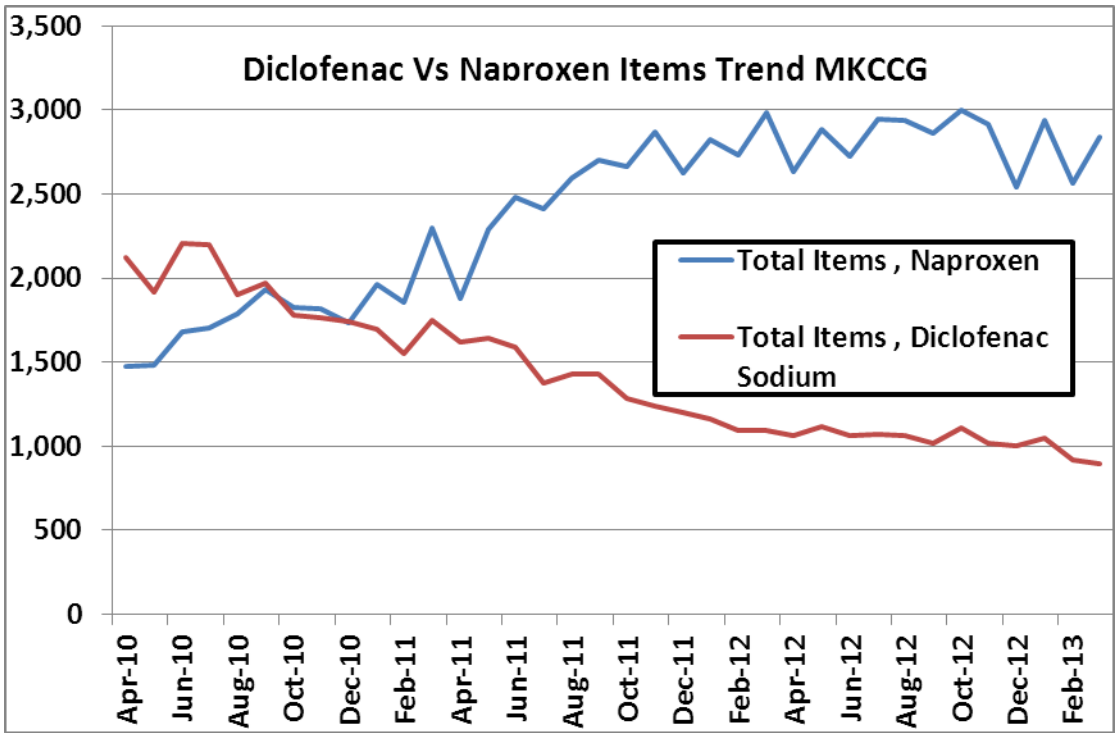
http://www.rcgp.org.uk/news/2013/january/addiction-to-medicines-consensus-statement.aspx

9 years since Vioxx and NSAIDs are still a concern

A recent study of NSAIDs use has once again highlighted the potential risks associated with the use of these medicines. NSAIDs are a mainstay for the treatment of painful conditions and many patients rely on them to maintain daily activities. NSAIDs have been shown to reduce pain significantly in patients with arthritis, low-back pain and soft tissue pain. However, there is a comprehensive body of evidence to suggest that, in spite of their popularity and availability over-the-counter, the clinical efficacy of NSAIDs does not come without a potential risk of significant cardiovascular harm. **In fact, one large meta-analysis has suggested that for all NSAIDs except naproxen the increased risk of CV events exceeds 30%.** As a comparison, smoking increases the risk of developing coronary artery disease by around 50–100%.

Recently, several studies have investigated the effect of NSAIDs on cardiovascular risk in patients with a history of cardiovascular disease and in presumed healthy people with no comorbidities showing an increase in risk of cardiovascular death, fatal and non-fatal myocardial infarction, and stroke.

The benefits of treating painful conditions with NSAIDs may, in general, outweigh the harms, but consider the harms before making treatment decisions. It is therefore good to see that the local prescribing data shows a significant decrease in the use of diclofenac and an increase in naproxen.



Information on antibiotic prescribing

The antimicrobial stewardship group has noted that both primary and secondary care want more information on antibiotics upon admission and discharge. Communication between the two sectors needs some improvement; such as clinicians recording antibiotics given to patients whilst in hospital on the discharge letter and medicines reconciliation upon admission to capture antibiotics administered in the community. Please make sure that you include information on recent antibiotics given to your patients if they go into hospital and make sure that information on allergy to penicillin is recorded where appropriate.

INHALER TECHNIQUE AUDIT – Reminder to Practices

Please book your one hour audit (from September onwards) with Sharon Wilmore on 01908 278702 or email: sharon1.wilmore@miltonkeynes.nhs.uk

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744