Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

March 2013

CCG Prescribing Group Meeting - 3rd March 2013

A range of topics were discussed, including:-

- Dr Paul Minney has resigned from the group. His contribution over many years is acknowledged with thanks.
- 2013-14 Prescribing Incentive Scheme was approved. Nikki will be attending April's Practice Manager's meeting to discuss the scheme.
- New regulations for Patient Group Directions. A letter will be issued to all users of PGDs authorising them to continue using PGDs issued by MK PCT even though the PCT will not exist after the end of March. The CCG assumes responsibility for the PGDs.
- Revised Empirical Guidance on the Management of Infection in Primary Care – sent with this newsletter. It is a very useful resource and it contains a new section on antibiotics for dental infections. This guidance supports the infections section of the joint formulary http://www.formularymk.nhs.uk/5-Infections/

Please note that the minutes of Prescribing Group Meetings can be seen on the formulary website – see http://www.formularymk.nhs.uk/

GMC Good practice guidance

The GMC has issued an updated version of its "Good Practice in prescribing and managing medicines and devices" guidance. It sets out 74 pieces of advice set out under a number of broad headings:-

- Keeping up to date and prescribing safely
- Need and objectivity
- Prescribing for self or family
- Consent
- Sharing information with colleagues
- Shared care
- Raising concerns
- Reporting ADRs, incidents etc
- Reviewing medicines
- Repeat prescribing
- Remote prescribing
- Prescribing unlicensed medicines
- Sports medicine

Whilst the advice is aimed at doctors, much of it is equally applicable to non-medical prescribers. The web link is http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

Hand written prescriptions

The team has noticed that some surgeries seem to hand-write a significant number of prescriptions for items that are on the GP system but can't be found. This potentially creates a safety / clinical governance / audit trail problem. Practices are asked to let their neighbourhood pharmacist know which items are being handwritten so that they can help you find them on the system.

Incorrect codes on prescriptions

Please make sure that when a medical or non-medical prescriber leaves the practice the PPD are informed. If this is not done, Milton Keynes CCG continues to pay for prescribing if the prescriber moves to a new practice outside the town. This has happened on a number of occasions recently and leads to CCGs having to cross-charge each other as well as inaccuracies in patient records.

The following information needs to be supplied:-
Full Name
GMC number (6 digit code)
Practice information
Date started / left
Capacity e.g. salaried, partner, locum

New Clinical Knowledge Summaries (CKS)

The new Clinical Knowledge Summaries (CKS) service provided by the National Institute for Health and Clinical Excellence (NICE) will be going live in early April 2013.

The new CKS service will provide summaries of the best available evidence and practical guidance on best practice in an accessible, easy to use format aimed at Primary Care Practitioners, covering a full range of Primary Care Presentations for over 300 primary care topics when it launches. It will also introduce up to 10 new primary care topics each year.

The new CKS service will replace the existing CKS service. The new service can be found at www.cks.nhs.uk.

Risk of developing Serotonin Syndrome following concomitant use of tramadol with SSRIs

Background

Serotonin (5- hydroxytryptamine, 5-HT) is a neurotransmitter with receptors in the nervous system, on the surface of platelets and on the vascular endothelium.

Serotonin neurotransmission is responsible for a large range of functions. In the central nervous system, serotonin assists in the regulation of wakefulness, affective behaviour, food intake, thermoregulation, migraine, emesis, sexual behaviour, regulation of nociception, and motor tone. In the periphery, the serotonin system assists in the regulation of vascular tone and gastro-intestinal activity.

Drugs may affect serotonin levels through inhibition of serotonin reuptake (e.g. selective serotonin reuptake inhibitors, SSRIs) and metabolism (e.g. monoamine oxidase inhibitors, MAOIs) at the postsynaptic receptor.

Serotonin syndrome occurs as a result of excess agonist activity at central and peripheral nervous system serotonin receptors. Excess serotonergic activity produces a spectrum of clinical findings from barely perceptible to lethal.

Serotonin syndrome is characterized 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

Patients with mild manifestations may present with subacute or chronic symptoms, whereas severe cases may progress rapidly to death.

Groups of drugs that have been associated with serotonin syndrome include monoamine oxidase inhibitors, SSRIs, tricyclic antidepressants, opiate analgesics, and antibiotics.

Tramadol may cause serotonin syndrome particularly when it is used at high doses (>400mg/24 hrs) or in combination with other agents increasing serotonin levels. The manufacturers of tramadol state that co-administration with serotonergic drugs, e.g. SSRIs or MAOIs, may lead to an increase of serotonin-associated effects, which can include serotonin syndrome.

A combination of agents increasing serotonin by different mechanisms, such as by inhibition of serotonin uptake and serotonin metabolism, is associated with a high risk of the syndrome. Symptoms usually occur following initiation of therapy or increases in dose of a drug that can increase serotonin levels.

The increasing availability of antidepressant agents with serotonergic properties has increased the number of reports of this syndrome in recent years.

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.

What is the problem?

There have been a number of case reports of serotonin syndrome following concomitant use of tramadol with SSRIs including citalopram, fluoxetine, sertraline and paroxetine.
In all the case reports symptoms developed within a few days of addition of the SSRI to tramadol therapy or vice versa, and equally symptoms resolved within days to a few weeks of discontinuation of the serotonergic agents. Patients and healthcare professionals should be aware of the potential for serotonin syndrome and monitor for any of the symptoms of serotonin syndrome on initiation and dose increases of all serotonergic medications.

Please be alert to this risk and avoid prescribing tramadol in combination with an SSRI.

Advisory Council on the Misuse of Drugs calls for tighter controls on tramadol

Tighter controls should be put on the painkiller tramadol according to the Advisory Council on the Misuse of Drugs (ACMD), the UK's official drugs advisers. The ACMD said it was concerned about an increase in the number of deaths related to misusing this psychoactive drug.

In a letter to the Home Secretary and Health Secretary, the ACMD has called for tramadol to be made a Class C drug, with penalties of up to two years in prison for possession and 14 years for supply. The ACMD stated that the number of deaths related to the drug was 154 in 2011—up from 87 in 2009 and 83 in 2008. The deaths were mostly linked to misuse.

Management of Tinea Capitis

Tinea capitis is a disease almost exclusively of childhood and current evidence would suggest it occurs more often in children of African or Caribbean extraction.

It is largely caused by *Trichophyton tonsurans.* The clinical signs may be subtle but include mild scaling in the scalp, broken off hairs and patches of alopecia. Pustules or inflammatory swellings (kerion) may also be present. If untreated it will spread to close contacts. Adults rarely have tinea capitis but parents may have discrete lesions on face, neck or arms.

Scrapings need to be sent for mycology. Direct microscopy can be done immediately to show the presence or absence of fungal hyphae. However, culture results take longer and a negative result cannot be confirmed until culture plates have been incubated for 6 weeks.

Treatment of clinically obvious cases should not be delayed.

Topical treatments are **NOT** effective in tinea capitis because the pathogenic fungi are located within the hair shaft.

There is no approved treatment for tinea capitis in childhood in the UK apart from Griseofulvin. Dose is 20mgs/kg for 8 weeks. The oral solution has again been withdrawn, making it an expensive unlicensed special. We recommend in line with the pharmaceutical advisers advice to prescribe tablets and advise parents to crush these and give on a spoon with yoghurt wherever possible.

However, a randomised controlled trial in 2007 found that cure rates for *trichophyton tonsurans* where significantly higher for Terbinafine than for Griseofulvin. Terbinafine is well tolerated. The dose is 62.5mgs daily if under 20kgs, 125mgs daily if 20-40kgs and over 40kgs is 250mgs daily for 4 weeks.
If mycology identifies *microsporum* infection then Griseofulvin is more effective.

Libby Pell
Dermatology Nurse Specialist

EU Directive (2010) to prevent sharps injuries

This directive requires organisations to put in measures to improve safety in advance of the legislation which comes into force 11 May 2013. Such measures include assessing the risk or occurrence of sharps injuries to health care workers, review procedures and change to safety engineered devices where practicable to do so.

Existing insulin pen needles remain exposed after insulin administration. Insulin syringes also have exposed needles after use.

By 11 May 2013, the following devices should be prescribed if the patient is having their insulin administered by a district nurse or other healthcare professional:

- BD Autoshield Pen tip 29g - FTR948
- BD SafetyGlide insulin syringe with needle:
  - FWD085 0.5ml Insulin syringe 30G 8mm
  - FWD087 0.3ml Insulin syringes 31G 8mm

References

Council Directive 2010/32/EU (2010) Implementing the framework agreement on prevention from sharps injuries in the hospital and health care sector, concluded by HOSPEEM and EPSU, *Official Journal of European Union*.

FIT4Safety 2012 Injection Safety in UK and Ireland: Safety of Sharps in Diabetes Recommendations 1st edition, FIT4Safety, UK
http://www.fit4diabetes.com/files/2613/3102/3031/FIT_Recommendations_Document.pdf
FIT4Safety Injection Safety in UK and Ireland
http://www.trend-uk.org/BD4224_FIT_Safety_05_V5_AW.pdf

Cohort study: Concurrent use of diuretics, angiotensin converting enzyme inhibitors and angiotensin receptor blockers with NSAIDs and risk of acute kidney injury.

Reference: **BMJ 2013;346:e8525**

Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) are often co-prescribed with non-steroidal anti-inflammatory drugs (NSAIDs) and diuretics, particularly in older people, and these patients are at theoretical high risk of acute kidney injury. However, little is known about the effects of drug-drug interactions on acute kidney injury.

To investigate further, researchers analysed retrospective data from a UK primary care database of 487,372 users of antihypertensive drugs who met the inclusion criteria. The researchers used a nested case-control design to examine whether adding an NSAID to an ACE inhibitor, ARB, or diuretic in double or triple therapy combinations increased the risk of subsequent hospital admission with acute kidney injury (primary endpoint).

During a mean follow-up of 5.9 years, the following results were reported:

• 2,215 cases of acute kidney injury were identified (incidence rate 7/10,000 person years).

• The current use of a double therapy combination containing either diuretics or angiotensin converting enzyme inhibitors or angiotensin receptor blockers with NSAIDs was not associated with an increased rate of acute kidney injury.

• The current use of a triple therapy combination was associated with an increased rate of acute kidney injury (rate ratio 1.31, 95% confidence interval 1.12 to 1.53).

• In secondary analyses, the highest risk was observed in the first 30 days of use (rate ratio 1.82, 1.35 to 2.46).

The researchers concluded that, “increased vigilance may be warranted when diuretics and ACE inhibitors or ARBs are used concurrently with NSAIDs. In particular, major attention should be paid early in the course of treatment, and a more appropriate use and choice among the available anti-inflammatory or analgesic drugs could therefore be applied in clinical practice.”

Implications of these findings on clinical practice:-
Clinicians should advise patients who are prescribed diuretics, ACE inhibitors, or ARBs of the risks associated with NSAID use and they must also be vigilant for signs of drug associated acute kidney injury.

Macrolides and Statins

We are seeing patients on simvastatin being given courses of macrolide antibiotics without advice to stop the statin for the duration of the course. The BNF notes that there is an **increased risk of myopathy when simvastatin is given with erythromycin and clarithromycin and therefore concomitant use should be avoided.**

MARTI Training

The RCGP has revamped its website recently. The MARTI module is now on the TARGET page along with lots of other antibiotic resources you may wish to use. To access, follow the link below and go into clinical resources, the MARTI training is a link on that page www.rcgp.org.uk/TARGETantibiotics/

Direct access to the page is via

http://www.rcgp.org.uk/courses-and-events/online-learning/ole/managing-acute-respiratory-tract-infections.aspx

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744