Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

March 2017

CCG Prescribing Group
1st March 2017

The key points discussed were:

- The content of the 2017-18 Prescribing Incentive Scheme was approved. It will go for Board sign off at the end of March and then circulated to practices. The scheme builds on targets in the 2016-17 version.
- Revised Paediatric Asthma guidelines were approved and will now go forward to MKPAG for wider discussion and approval.
- Public Health England has updated its antimicrobial guidance so the group is working on our local version. This will be circulated as soon as possible.
- Terms of Reference were updated.
- There is still a vacancy for one GP so if you would like to get involved, please contact Janet Corbett.

Milton Keynes Prescribing Advisory Group (MKPAG)
22nd March 2017

The key points discussed were:

- Revised guidance for the management of asthma in adults and children were agreed. These will be circulated shortly. Please note that they contain changes to the use of pharmacological agents as recommended by British Thoracic Society.
- In Vita D3 800iu capsules were added to the formulary in place of Fultium D3 800iu capsules. Desunin 800iu tablets were also added – as they do not contain gelatin, they are suitable for vegans and vegetarians.
- Budenofalk rectal Foam® containing Budesonide 2 gram per delivered dose was added to the formulary as Predfoam Enemas have become very expensive.
- Sanatogen A-Z is temporarily unavailable so Forceval should be prescribed – but only on the recommendation of Gastro team or dietitians.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website:
http://www.formularymk.nhs.uk/Minutes/

Medicines optimisation service – an update from Sue Marshall and Steph Deane

The medicine optimisation service is a pilot service (funded to March 2018) and has now been running in Milton Keynes CCG since September 2016. We have made links across health and social care and with community pharmacies, and have supported patients both in their own homes and those residing in care homes. We have worked closely with GP practices and thank those who have welcomed us and embraced our role.

We have seen in excess of 100 patients in their own homes looking at medicine use and waste, resulting in significant savings and more importantly increasing patient safety and understanding.

We are currently working with practices to review their Repeat Prescribing Processes and give advice on producing a robust policy. Evidence elsewhere has shown by having a robust repeat prescribing system in place not only improves patient safety, reduces GP workload and reduces waste but improves patient satisfaction.

If you would like to find out more about our service, like some help with reviewing your repeat prescribing system or have patients you feel would benefit from our input then please get in touch, we would be delighted to meet with you and your staff. Drop us an email to mkccgpharmacy@nhs.net

Tests ordered by hospital clinicians in outpatients unrelated to reason for referral.

We are aware that occasionally in outpatient appointments a patient mentions a problem that is unrelated to their referral. For example a patient who comes to clinic for X reason. Whilst they are there, they mentioned being symptomatic for UTI (not related to X reason for appointment). In order to provide best care for the patient, the consultant will request a urine sample and then send the results to the GP. We have evidence of some GPs sending the results back for the Consultant to take any necessary actions including issuing a prescription.

This is a bit of a grey area as it's not what the patient came for and so theoretically the hospital should say to the patient that they won't deal with it and send them back to the GP. But that's not in the best interests of the patient. However if they are an outpatient the hospital clinician won't necessarily have all details of allergies etc from which to prescribe safely. So for these two reasons it would seem reasonable to send the results to the GP for treatment but we have asked the hospital clinicians to be clear in their communication that they took a sample to expedite care for the patient and as it is outside the referral they cannot follow up the results and therefore would be grateful if the GP could do so.

More about Deprescribing

In the last edition of Prescribing News, we introduced the concept of deprescribing. As a reminder, deprescribing can be defined as the process of tapering, stopping, discontinuing or withdrawing medicines with the goal of managing polypharmacy and improving outcomes. Clinicians are often reluctant to disturb the status quo by withdrawing medication but evidence suggests that with engagement and informed consent, patients welcome the fact that medication regimens are being individualised and tailored to their needs. Medico-legally, deprescribing is no different to prescribing within the UK legal system. Patient consent to stop, start or reduce a medicine must be based on full disclosure of all material risks to the patient.

The 2017-18 Prescribing Incentive Scheme contains an element which will encourage practices to identify patients aged over 75 years who are taking at least 9 oral medications and for each GP to review 3 patients on this list. This may provide an opportunity to deprescribe as well as prescribe.

Benefits of deprescribing

Patients often remain on medicines that have the potential to cause adverse effects and where the harms of the drug outweigh the benefits. It is also recognised that people who once derived benefit from prescribed medicines may not continue to do so but their treatments are not always stopped once this point is reached.

Most medicines do not need to be used life-long and the benefits and risks of medicines in an individual patient need to be regularly reassessed.

Stopping medicines or 'de-prescribing' may therefore be a viable option in patients who have either experienced or remain at high risk of a significant adverse reaction, and/or for whom there may no longer be a clinical benefit from remaining on the medicine. New evidence and guidelines may also influence the decision to continue or withdraw a medicine.

Frail patients with multimorbidity may be at higher risk of adverse drug reactions and medicine interactions. Preventative 'risk modifying' medicines may not have a favourable risk/benefit profile especially in the longer term. The challenge is recognising the appropriate point to review and consider de-prescribing.

One important aspect that needs to be considered when reviewing prescriptions is the **Anticholinergic Burden (ACB).** Anticholinergics should be prescribed with caution as elderly patients are more likely to experience adverse effects such as constipation, urinary retention, dry mouth/eyes, sedation, confusion, delirium, photophobia, falls, and reduced cognition. Research also suggests a link to increased mortality with the number and potency of anticholinergic agents. It is estimated that each anticholinergic may increase risk of cognitive impairment by 46% over 6 years.

The Anticholinergic Rating Scale is useful to raise awareness of the anticholinergic effects of different medicines. A number of studies have been published which aim to assign drugs with one, two, or three points; the higher the number, the stronger the anticholinergic effect. A score of 3 or more is considered clinically significant.

1 point	2 points	3 points
Haloperidol	Clozapine	Chlorpromazine
Quetiapine	Nortriptyline	Amitriptyline
Mirtazapine	Baclofen	Imipramine
Paroxetine	Cetirizine	Chlorphenamine
Trazodone	Loratadine	Hydroxyzine
Ranitidine	Cimetidine	Oxybutynin, solifenacin, trospium, propiverine
Venlafaxine	Loperamide	
Loratidine, desloratidine, cetirizine	Prochlorperazine	

GP practices can identify and review patients prescribed combinations of anticholinergic drugs from their clinical system and should:-

- Minimise use of anticholinergics wherever possible.
- Consider anticholinergic burden scale when prescribing anticholinergic combinations. Avoid prescribing anticholinergics with acetylcholinesterase inhibitors e.g. donepezil, rivastigmine (can worsen cognitive impairment).
- Proactively monitor at regular intervals for efficacy and tolerance e.g. annually (or 6 monthly in patients over 75 years) once clinically stable.
- If suspicion of anticholinergic induced impaired cognition, carry out a mini mental state examination (or equivalent) and consider switching or stopping if confirmed and clinically appropriate.
- Refer patients suffering from significant anticholinergic side effects due to psychotropic medication to an appropriate specialist.

Acute Kidney Injury (AKI)

AKI is a clinical syndrome that is common, harmful and avoidable. Irrespective of severity, AKI increases the risk of chronic kidney disease and further episodes of acute injury. In the UK, up to 100,000 deaths each year in hospital are associated with AKI and up to 30% of these could be prevented. About 65% of acute kidney injury starts in the community. The "Think Kidneys" programme aims to prevent avoidable harm. For more details, please see https://www.thinkkidneys.nhs.uk/

Risk factors for AKI

These include:-

- CKD, age over 65 years, heart failure, diabetes, liver disease, previous history of AKI, neurological or cognitive impairment leading to poor fluid intake

AKI may also be triggered by:

- Sepsis or infections, hypovolaemia from bleeding or dehydration, hypotension e.g. after heart attack and certain high risk medicines including diuretics, ACEI, ARBs, NSAIDs, metformin.

Sick Day Guidance

- Healthcare professionals should identify patients at higher risk of AKI. At risk patients should be informed that during an illness that causes dehydration, certain medicines can either increase the risk of dehydration or lead to potentially serious side effects of the medicine. Causes of dehydration may include viral illnesses, vomiting, diarrhoea, high temperature, sweating.
- Based on an individual risk assessment, healthcare professionals should provide advice on temporary cessation of medicines
- Patients should be counselled on the importance of maintaining good fluid intake (at least 6-8 glasses of fluid per day e.g. tea, squash, oral rehydration sachets etc.) Also give practical advice like taking sips of fluid regularly throughout the day.
- Patients should be informed that medicines should be restarted once they feel better (24-48 hours after resuming eating and drinking normally). Patients previously stabilised on ACEi or ARB may need to be re-titrated to their previous dose and reviewed within 4-6 weeks.
- Patients should be advised that they may take paracetamol for pain relief or fever but they should avoid NSAIDs.
- Episodes of AKI should be READ Coded, noting the cause.

What about patients with Heart Failure?

The British Society for heart Failure states that if AKI is highlighted in a patient with heart failure the priority is to ensure that the patient receives a careful clinical assessment before a decision is made as to whether treatment change is warranted. It is important to remember that patients presenting with decompensated heart failure often suffer deterioration in renal function as a consequence of the fluid overload. Diuresis is the mainstay of treatment in these situations and withholding drugs may well do more harm – tailoring care to the individual is key.

Acute Kidney injury – Potentially Problematic Medicines and Actions to Take

Medicine	Effects on renal/fluid/electrolyte physiology	Change in side effect profile	Action in presence of AKI
ACEi/ARB/Aliskiren	Hypotension Hyperkalaemia		Consider alternatives; in heart failure –seek specialist advice
Thiazide and loop diuretics	Volume depletion		Monitor and adjust dose accordingly
Antihypertensives inc calcium channel blockers and beta blockers	Hypotension may exacerbate renal hypo-perfusion	Risk of bradycardia increased with beta blockers	Consider withholding or reduce dose depending on clinical signs
NSAIDs and Coxibs	Altered haemodynamics		Avoid
Hypoglycaemic drugs		Accumulation may increase risk of hypoglycaemia	Avoid long acting preparations. Monitor glucose levels and reduce dose if necessary
Metformin		Increased risk of lactic acidosis Accumulation may increase risk of hypoglycaemia	Avoid if GFR <30ml/min
Opioid analgesics		Accumulation and risk of CNS side effects and respiratory depression	Avoid long acting preparations. Reduce dose.

Pregabalin and Gabapentin		Accumulation and risk of CNS side effects	Reduce dose
Statins, fibrates		Increased risk of rhabdomyolysis	Stop if AKI due to rhabdomyolysis. Otherwise continue but monitor. Stop if patient develops unexplained persistent muscle pain
Lithium	Can cause nephrogenic diabetes insipidus. Very rarely associated with neuroleptic malignant syndrome	Accumulation increases risk of side effects. Kidney impairment exacerbated in hypovolaemia and in combination with ACEI / ARB / NSAIDs	Avoid if possible. Monitor lithium levels. Monitor electrolytes. Encourage good fluid intake
Trimethoprim	Increased risk of hyperkalaemia. Interferes with tubular secretion of creatinine	Accumulation increases risk of hyperkalaemia	Avoid or reduce dose particularly if patient already taking ACEI, ARB or spironolactone
Phenytoin		Risk of phenytoin toxicity if patient has low serum albumin levels	Monitor levels, Correct phenytoin levels for uraemia and low serum albumin
Digoxin	Hyperkalaemia	May accumulate in AKI leading to bradycardia, visual disturbances, mental confusion	Reduce dose. Monitor drug level.
Colchicine		Diarrhoea, vomiting causing hypovolaemia	Low doses eg 500mcg bd or tds are effective. Avoid NSAIDs for gout.

References

- Think Kidneys website: www.thinkkidneys.nhs.uk/
- Sick day rules in kidney disease. Drugs and Therapeutics Bulletin 2015;4:317
- Acute kidney injury: prevention, detection and management. NICE CG169. August 2013. http://www.nice.org.uk/guidance/cg169
- Griffith K. et al. “Sick day rule” in patients at risk of Acute Kidney Injury: an Interim Position Statement from the Think Kidneys Board. July 2015.
- Acute Kidney Injury: NICE Quality Standard 76: http://www.nice.org.uk/guidance/qs76
- Acute kidney injury. Centre for Pharmacy Postgraduate Education. September 2015
- British Society for heart Failure Position statement
- Scottish Patient safety Programme. Medicines sick day rules card. 2015. http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/medicine-sick-day-rules-card
- Medicines and Dehydration Briefing for Professionals on the Medicine Sick Day Rules card http://www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Primary%20Care/Medicines%20Sick%20Day%20Rules%20cards/MSDRHealthProfessionalsLeaflet.pdf
- AKI Guidance Buckinghamshire CCGs http://psnc.org.uk/buckinghamshire-lpc/wp-content/uploads/sites/30/2016/07/Intervention-AKI-March-2016.pdf

Nystatin Dose Change

The BNF has amended the dose of Nystatin for oral candidiasis to:-

- Neonate (under 1month):1ml qds; Infant 1month to 2 years: 2ml qds; Child 2 years to adult: 4-6ml qds. Due to large volume of Nystatin required consider use of Daktarin Oral gel as a suitable alternative in anyone aged 4 months or older (6 months if baby born pre-term). However, miconazole, including the topical gel formulation, can enhance the anticoagulant effect of warfarin—if miconazole and warfarin are used concurrently, the anticoagulant effect should be carefully monitored and, if necessary, the dose of warfarin reduced.

https://www.evidence.nhs.uk/formulary/bnf/current/12-ear-nose-and-oropharynx/123-drugs-acting-on-the-oropharynx/1232-oropharyngeal-anti-infective-drugs/oropharyngeal-fungal-infections

The Pharmaceutical Advisers can be contacted on 01908 278744 or 01908 278713 or speak to your neighbourhood pharmacist