Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

November 2015

CCG Prescribing Group Meeting 4th November 2015

The key points discussed were:

- The COPD and pain guidance was discussed and comments will be taken back to secondary care.
- Mechanisms for reducing waste in repeat prescribing. Please look out for further information.
- Formulary for oral nutritional supplements was noted.

Milton Keynes Prescribing Advisory Group (MKPAG) 23rd September 2015

The key points discussed were:

- The Pain and COPD guidelines are still being worked on. They will be issued when they are finished.
- The Oral Nutritional Supplement Formulary was referred to the hospital Nutrition Steering Group for consideration. In the meantime practices should follow the guidance supplied by Ruth Hammond, Prescribing Team Dietitian.

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

OptimiseRx SystmOne Development Request

The Pharmaceutical Advisers need you to please support a request to SystmOne to allow the dosage instructions to be retained if OptimiseRx prompts you to choose another formulation. This should remedy the problem of losing details such as a steroid reducing dose regimen. The problem lays within SystmOne and not within OptimiseRx but we need prescribers to vote to highlight it as a priority for development by SystmOne.

The newsletter insert gives information on using the SystmOne voting buttons.

Caution: MHRA warns of risk of subacute cutaneous lupus erythematosus with PPIs

Proton pump inhibitors (PPIs) are associated with very infrequent cases of subacute cutaneous lupus erythematosus (SCLE), a non-scarring dermatosis that can develop in sun-exposed areas. (Drug Safety Update vol 9 issue 2 September 2015: 1.) Considering the extensive use of PPIs, very few cases of SCLE have been reported. Nevertheless, evidence from clinical literature and from cases reported to medicines regulators including via the Yellow Card Scheme supports a causal association between PPIs and SCLE. Product information is being updated to include this advice for healthcare professionals and patients or carers.

A Swedish case-control study that linked a patient register with a prescribed-drug register estimated that the risk of developing SCLE was almost 3 times higher in patients on PPIs compared with that of the general population (odds ratio 2.9 [95% CI: 2.0–4.0]). A review of medical records of patients at a dermatology unit in a university hospital in Denmark identified 19 cases of SCLE associated with PPIs over 19 years. Of these, 3 cases were classified as definitely caused by a PPI and 14 were classified as probable. A further 17 cases of SCLE after PPI use have been reported in clinical literature. Cumulatively, of the cases reviewed from literature and from case reports submitted by PPI licence holders to medicines regulators, there have been 36 cases of positive de-challenge (ie, SCLE resolved on stopping PPI) and 4 cases of positive re-challenge (ie, SCLE reoccurred with a different PPI to the one that first triggered the condition).

Advice to prescribers
If a patient treated with a proton pump inhibitor (PPI) develops lesions—especially in sun-exposed areas of the skin—and it is accompanied by arthralgia:

- advise them to avoid exposing the skin to sunlight
- consider subacute cutaneous lupus erythematosus (SCLE) as a possible diagnosis
- consider stopping use of the PPI unless it is imperative for a serious acid-related condition; a patient who develops SCLE with a particular PPI may be at risk of the same reaction with another
- in most cases, symptoms resolve on PPI withdrawal; topical or systemic steroids might be necessary for treatment of SCLE only if there are no signs of remission after a few weeks or months
- report any suspected side effect with PPIs on a Yellow Card

Always try to titrate down to the lowest effective dose and review on-going need for a PPI.

NHS Prescriptions after private consultations

The Pharmaceutical Advisers often get asked whether GPs can or should prescribe medicines on the NHS after a patient has had a private consultation.

The responsibility for prescribing rests with the doctor who has clinical responsibility for a particular aspect of the patient's care. Where, for instance, an NHS doctor refers a patient to a consultant for advice but, when appropriate, retains clinical responsibility, he/she should issue the necessary prescriptions at NHS expense.

Following a private consultation, there is no obligation for the GP to prescribe the recommended treatment if it is contrary to the local formulary or guidance or his/her normal clinical practice.

Patients may commence care privately, but then request that further treatment be provided within the NHS. In this case, the patient may be transferred to the NHS and should be re-assessed for NHS treatment within the same criteria applicable to NHS patients. **If the patient insists on being prescribed a non-formulary medicine rather than the locally approved choice then they should obtain this from their Private Consultant.**

Patients receiving NHS funded infertility treatment should receive their medication through the treatment providers as part of that contract, not via GP prescription.

If the doctor decides to prescribe on an NHS prescription, then the practice is at liberty to enforce the usual 72 hour rule for a prescription to be ready.

Reference
The British Medical Association Interface between NHS and private treatment - February 2009

Guidance on lancet choices for self-use by patients

Patients needing to self-monitor blood glucose (where appropriate) will also need to be prescribed lancets to use with a finger pricking (lancing) device. This is used to prick the patient's finger to withdraw a small amount of blood, in order to test blood glucose levels. Lancets are available in different sizes; the higher the gauge, the smaller the diameter of the needle. A higher gauge lancet is generally less painful, but may not provide sufficient blood for testing. Milton Keynes CCG spends approximately £80K on lancets annually.

This article provides some recommendations to help ensure appropriate and cost-effective use.

Recommendations

- Use the least costly lancets that are suitable for the individual patient - these may not be the one provided with the meter. The most cost-effective lancets are:
    - 30 Gauge: CareSens lancet, 0.31mm/30 gauge or GlucoRx 0.31mm/30 gauge
    - 28 Gauge: CareSens 0.36mm/28 gauge
- Lancets are designed to fit into proprietary finger-pricking devices. However most single use lancets can fit several devices.
- Finger pricking devices are not prescribable on an FP10 as they are not listed as appliances under Part IXA of the Drug Tariff. Finger pricking devices are supplied with the blood glucose monitoring meter.
- Patients who have special visual or psychological needs should be provided with injection devices or needle-free systems that they can use independently for accurate dosing.
- Multi-device lancets which contain a preloaded lancet drum e.g. Fastclix or Multiclix, should be restricted to those with clinical need, e.g. those with dexterity problems or children where disposal of sharps may be impractical or difficult.
- Safety lancets are designed so that the sharp retracts after use. These are primarily for the benefit of healthcare workers to avoid needle stick injury, not to be used by patients self-monitoring blood glucose; therefore they should not routinely be prescribed by GPs on FP10s.
- Ensure that quantities on prescription are appropriate and in line with frequency of testing (i.e. should match quantities and frequency of ordering of blood glucose test strips). Consider whether they should go on repeat?
- Lancets are for single use only, patients should be provided with suitable containers for the collection of used lancets. Arrangements should be available for the suitable disposal of these containers.
- Lancets for self-use must not be used by healthcare workers to take samples from more than one patient.

Acknowledgement - These recommendations have been adapted from a PrescQIPP bulletin (B104i) on lancets.

Patient Safety Alert: Mirabegron in uncontrolled hypertension

The MHRA has warned prescribers that Mirabegron (Betmiga) is contraindicated in patients with severe uncontrolled hypertension (systolic blood pressure ≥180 mm Hg or diastolic blood pressure ≥110 mm Hg, or both).https://www.gov.uk/drug-safety-update/mirabegron-betmiga-risk-of-severe-hypertension-and-associated-cerebrovascular-and-cardiac-events

A letter has also been sent to healthcare professionals about mirabegron for symptomatic treatment of urgency, increased micturition frequency, or urgency incontinence. https://www.gov.uk/drug-safety-update/letters-sent-to-healthcare-professionals-in-september-2015

Blood pressure should be measured before starting treatment and monitored regularly during treatment, especially in patients with hypertension.

In addition, Mirabegron is not recommended in patients with severe renal impairment (ie, GFR 15–29 mL/min/1.73 m^2) or in those with moderate hepatic impairment (ie, Child-Pugh Class B) who are also taking strong inhibitors of cytochrome P450 3A such as itraconazole, ketoconazole, ritonavir, or clarithromycin.

The dose of mirabegron in patients with mild to moderate renal impairment (ie, GFR 30–89 mL/min/1.73 m^2) or those with mild hepatic impairment (ie, Child-Pugh Class A) who are also taking strong inhibitors of cytochrome P450 3A should be reduced to 25 mg once daily.

Please take this new warning into consideration when you are reviewing patients as part of the Prescribing Incentive Scheme and refer to the local OAB Guidance for the place of Mirabegron in therapy. The guidance is available on SystmOne and the formulary website (Chapter 7 Appendix) www.formularymk.nhs.uk

Learning from a critical incident

We are grateful to a practice for sharing a critical incident with the Pharmaceutical Advisers as it has enabled us to put in place actions to stop a similar problem happening elsewhere.

What happened?

The GP prescribed Mirena® generically as levonorgestrel 52mg T-shaped intrauterine system releasing approx. 20 microgram/24 hours without realising that the community pharmacists could correctly fulfil the prescription with either Mirena or Levosert. Each meets the generic description although the former needs replacing after 5 years and the latter after 3 years. Thus there is a risk that the patient would receive a product the she and the GP thought lasted 5 years when in fact it should be changed in 3 years.

What actions have been taken?

1. Warning on SystmOne MK Formulary added – recommendation to prescribe by brand
2. Message added to OptimiseRx - recommendation to prescribe by brand
3. Concern raised with MHRA by email as this is a national safety concern
4. Request for a warning to be published in Local Pharmaceutical Committee newsletter to remind community pharmacists to ask which brand is required if they receive a prescription written generically.

Co-danthramer discontinued

Please note that co-danthramer capsules have been discontinued. Please consider using Movicol and sodium picosulfate as alternatives.

Sharps disposal

There have been some problems recently with patients turning up at MKUHFT with sharps for disposal – sometimes in carrier bags. The patients are reported to have said the GP will not provide a sharp box or won't accept them back once full. The guidance (Safe Management of Healthcare Waste) is quite clear around this:

Self-medicating patients and sharps disposal

Where the householder is a self-medicating patient who uses injectables (for example a person with diabetes) with no healthcare worker involved in the administration, the GP or healthcare worker should prescribe the householder a sharps receptacle relevant to the medication being administered and advise them of local disposal options.

Once the sharps receptacle is filled to the "fill line", it should be sealed by the householder and taken back to the GP surgery for disposal or arrangements for collections should be made with the local authority. For self-medicating housebound patients, the GP or healthcare worker responsible for prescribing treatment should advise on collection arrangements.

Guidance on switching between anticoagulants

From ↓ To →	Warfarin	LMWH	Rivaroxaban	Apixaban	Dabigatran
Warfarin		**Tx DVT/PE**: stop warfarin and initiate treatment dose of LMWH once INR <2.0. **Prevention stroke and systemic embolism**: review thrombotic risk and consider initiating LMWH once INR <2.0	**DVT, PE treatment and prevention of recurrence:** stop warfarin and initiate Rivaroxaban once INR <2.5 **Prevention stroke and systemic embolism:** stop warfarin and initiate Rivaroxaban once INR ≤ 3.0	Discontinue warfarin and commence Apixaban once INR is < 2.0.	Discontinue warfarin and commence Dabigatran once INR is < 2.0.
LMWH	Commence warfarin in combination with LMWH and monitor INR. Discontinue LMWH once INR in therapeutic range for 2 consecutive days		Discontinue LMWH and commence Rivaroxaban 0-2hrs before the time that the next scheduled dose of LMWH would be due.	Discontinue LMWH and commence Apixaban at the time that the next scheduled dose of LMWH would be due.	Discontinue LMWH and commence Dabigatran 0-2hrs before the time that the next scheduled dose of LMWH would be due.
Rivaroxaban	Commence warfarin in combination with Rivaroxaban and monitor INR. Discontinue Rivaroxaban once INR ≥ 2.0. Measure INR prior to each dose of Rivaroxaban being administered.	Discontinue Rivaroxaban and commence LMWH at the time that the next scheduled dose of Rivaroxaban would be due.		Discontinue Rivaroxaban and commence Apixaban at the time that the next scheduled dose of Rivaroxaban would be due.	Discontinue Rivaroxaban and commence Dabigatran at the time that the next scheduled dose of Rivaroxaban would be due.
Apixaban	Commence warfarin in combination with Apixaban and monitor INR. Apixaban should be continued for 2 days after which INR should be measured prior to each dose being administered. Apixaban should be stopped when INR ≥ 2.0	Discontinue Apixaban and commence LMWH at the time that the next scheduled dose of Apixaban would be due.	Discontinue Apixaban and commence Rivaroxaban at the time that the next scheduled dose of Apixaban would be due.		Discontinue Apixaban and commence Dabigatran at the time that the next scheduled dose of Apixaban would be due.
Dabigatran	Conversion depends on renal function. For CrCL ≥ 50ml/min commence warfarin 3 days prior to stopping Dabigatran. For CrCL 30-50ml/min commence warfarin 2 days prior to stopping Dabigatran. NB Dabigatran can increase INR so INR measurements should be treated cautiously until 2 days after stopping Dabigatran.	Discontinue Dabigatran and commence LMWH 12 hours after last dose of Dabigatran was administered	Discontinue Dabigatran and commence Rivaroxaban at the time that the next scheduled dose of Dabigatran would be due.	Discontinue Dabigatran and commence Apixaban at the time that the next scheduled dose of Dabigatran would be due.	

References:

1. Summary of Product Characteristics for Xarelto 20mg tablets EMC last updated 17/7/15
2. Summary of Product Characteristics for Eliquis 5mg tablets EMC last updated 1/10/15
3. Summary of Product Characteristics for Pradaxa 150mg tablets EMC last updated 27/10/15
4. NICE CG 144 Venous Thromboembolic Disease http://www.nice.org.uk
5. Heidbuchel H, Verhamme P et al. European Heart Rhythm Association Practical Guidance on NOACs http://europace.oxfordjournals.or/content/europace/15/5/625full.pdf

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