# PRESCRIBING NEWS

NHS Milton Keynes

October 2011

**Update from Prescribing Group, September 2011**

- A range of Patient Group Directions were approved including one for seasonal flu which the practices should be using at the immunisation sessions.
- A revised policy for self monitoring of blood glucose and supporting patient information leaflet was reviewed. It has been circulated to practices.
- The community pharmacy New Medicines Service started on 1st October. GPs may refer patients to the pharmacist for additional support when starting certain new medicines.
- The GPs on Prescribing Group felt that Denosumab was unsuitable for shared care – this view was taken to Medicines and Therapeutics Committee. It means that secondary care remains responsible for this medicine.

**Update from Medicines and Therapeutics Committee, September 2011**

- Several types of eye drops for glaucoma were added to the formulary – see page 3 for details
- Olopatadine (Opatanol) was added as a second line agent for seasonal allergic conjunctivitis if sodium cromoglicate is ineffective. Please note that treatment should be limited to **4 months maximum.**
- Sodium valproate as Episenta prolonged release capsules and granules were approved particularly for people with swallowing problems. The contents of the capsules may be sprinkled on food.
- The primary care view of denosumab was noted.

**New web based formulary coming soon – please look out for further information!**

**Update on work to support better use of inhalers for respiratory disorders**

The Pharmaceutical Advisers are continuing to support work aimed at improving patients' use of inhaler devices. You will be aware of the training of healthcare professionals that has been done over the past two years. Attention is now focused on the patients.

A range of bespoke patient information leaflets for each device will be circulated to practices and pharmacies shortly. These will support you when explaining inhaler technique to patients. In addition, a poster has been developed for healthcare professionals. (Thanks to Nikki Woodhall for developing these.)

Community pharmacists have been undertaking targeted Medicine Use Reviews also designed to support this group of patients. So far 25 pharmacies have engaged with this project and they have delivered 590 targeted respiratory MURs plus 62 second interventions (3 months after the first).

Nikki Hughes has provided this summary of early findings:-
Overall **24%** of patients had **not seen their GP or nurse for more than 12 months** – all inhaler users should attend a review appointment at the practice annually, but GPs report that many do not attend these reviews. However it seems that pharmacies do see some of these harder to reach patients giving them an opportunity to pass on essential messages including the importance of patients attending their annual reviews at the surgery. Pharmacists make sure patients know that the pharmacy review is not a substitute and proactively encourage patients to attend surgery reviews and take their inhalers with them.

So far **14** people have been **referred to the pharmacy** for the respiratory MUR by their GP or nurse. This shows that the service is beginning to be valued by other sectors and that collaborative working is possible.
Generally patients are **aware of their diagnosis** – only **7%** did not know their diagnosis.

162 patients were **smokers** at first intervention – 27% of the inhaler users. Of these **46 accepted referral** into stop smoking support at the first MUR **(28%)** a very good acceptance rate. By the second intervention 38 people were still smoking and a further 4 accepted referral at this stage. By the second intervention **6 smokers had quit**.

**56.4% asthma patients** showed a better symptom control score by their second visit to the pharmacy
**65% COPD patients** improved symptom control by their second visit
**Overall – combining both groups, 60% patients showed better symptom control.**
There were few changes to medication between the first and second interventions. However fewer compliance issues concerning patient belief, understanding and device technique were reported at the second intervention. These results show that the pharmacist intervention does impact on patient care.

**NICE Clinical Guideline on the Management of Hypertension (CG 127, August 2011)**
This updated guidance (written in collaboration with the British Hypertension Society), contains a number of changes from previous guidance. The full guidance can be found at http://www.nice.org.uk/cg127

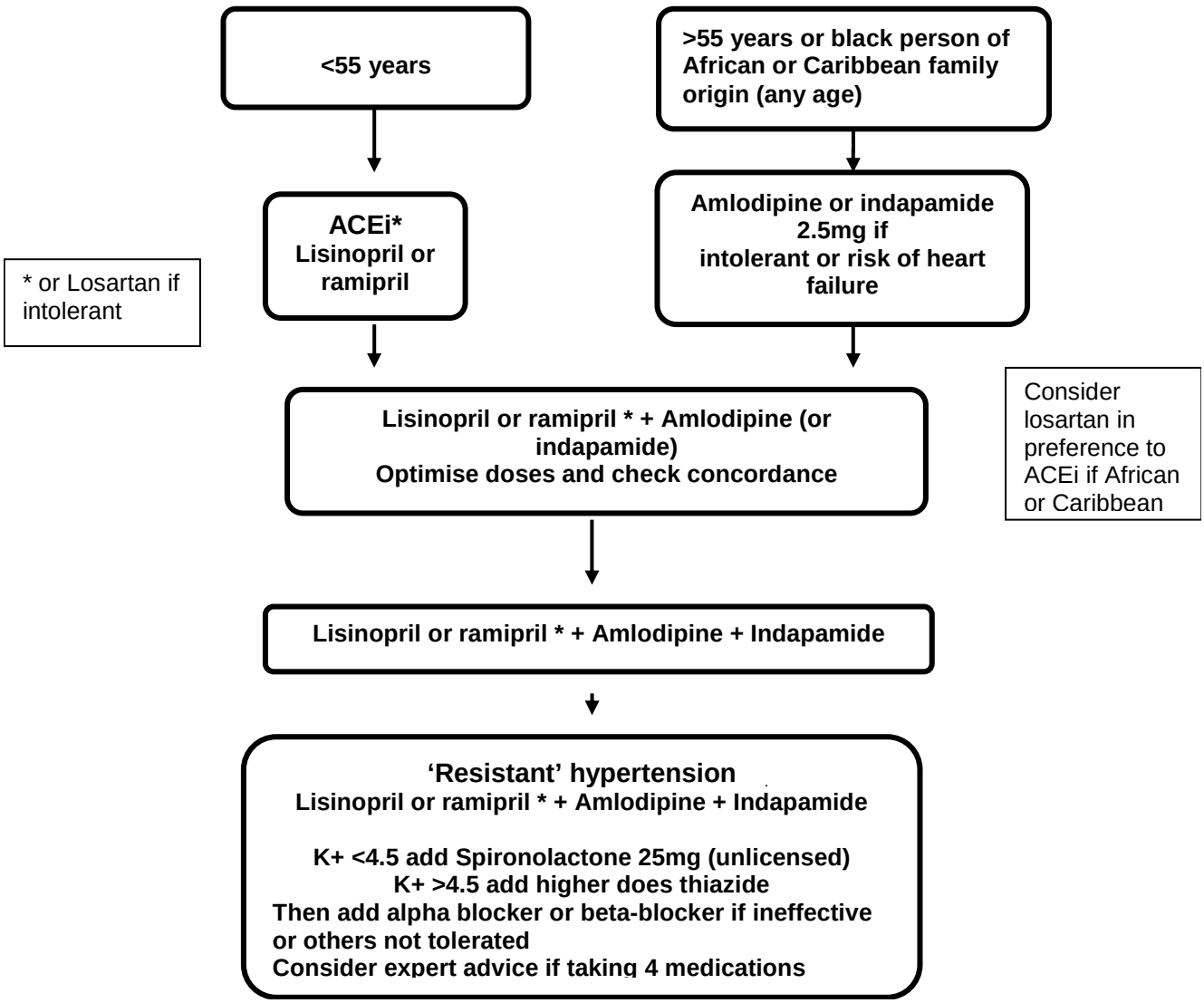
Key changes include:-

- The use of ambulatory BP monitoring (ABPM) or Home BP monitoring (HBPM) to confirm the diagnosis
- New terminology for the grades of hypertension
  - Stage 1: clinic BP ≥140/90mmHg **and** ABPM daytime average ≥135/85mmHg
  - Stage 2: clinic BP ≥160/100mmHg **and** ABPM daytime average ≥150/95mmHg
  - Severe: clinic systolic BP ≥180mmHg **or** clinic diastolic BP ≥ 110mmHg
- Blood pressure targets (Clinic BP)
  - Aged < 80 years: aim for BP < 140/90mmHg
  - Aged > 80 years: aim for BP < 150/90mmHg
- Blood pressure targets (ABPM daytime average or HBPM)
  - Aged < 80 years: aim for BP < 135/85mmHg
  - Aged > 80 years: aim for BP < 145/85mmHg

Prescribing advice:

- ❖ Prescribe generically
- ❖ Prescribe medicines taken once a day if possible
- ❖ Give patients > 80 years the same treatment as patients > 55 years, taking into account any co morbidity and concurrent medicines.
- ❖ Give patients with isolated systolic hypertension the same treatment as patients with both raised systolic and diastolic BP.
- ❖ Use a low cost sartan (losartan) if ACEi not tolerated; do not use both.
- ❖ Continue with bendroflumethiazide if BP is stable; if using indapamide – use 2.5mg not the modified release
- ❖ Beta blockers could be used in younger people if ACEi / sartan contra-indicated or where there is evidence of sympathetic drive or in women of child bearing potential.

Treatment algorithm



**Eye drops for the treatment of Glaucoma and ocular hypertension**

Dr Suri Dhanoa, Associate Specialist Ophthalmology provided the following useful notes to support applications to Medicines and Therapeutics for a wider range of eye drops.

Treatment of Ocular Hypertension (OHT) and suspected Chronic Open Angle Glaucoma (COAG)

- Above average central corneal thickness – treat with beta-blockers 1st line timolol 0.25% bd, 2nd line Timoptol LA od
- Below average central corneal thickness – treat with prostaglandin analogue 1st line bimatoprost, 2nd line latanoprost
- If intolerant of current medication or intraocular pressure not sufficiently reduced by above use alternative pharmacological treatment (prostaglandin analogue (as above), beta-blocker (as above), carbonic anhydrase inhibitor (1st line dorzolamide, 2nd line brinzolamide or sympathomimetic (1st line brimonidine))
- More than one drug may be needed to achieve target intra ocular pressure
- Offer preservative free preparation to patients with OHT or suspected COAG known to have an allergy to preservatives 1st line tafluprost as Saflutan unit dose eye drops, 2nd line timolol preservative free, 3rd line dorzolamide as Trusopt unit dose eye drops preservative free

Treatment of diagnosed Chronic Open Angle Glaucoma (COAG)

- Newly diagnosed early or moderate COAG treat with prostaglandin analogue 1st line bimatoprost, 2nd line latanoprost
- If intolerant of current medication or intraocular pressure not sufficiently reduced by above use alternative pharmacological treatment (beta-blocker (1st line timolol 0.25% bd, 2nd line Timoptol LA od) , carbonic anhydrase inhibitor (1st line dorzolamide, 2nd line brinzolamide or sympathomimetic (1st line brimonidine))
- More than one drug may be needed to achieve target intra-ocular pressure
- Offer preservative free preparation to patients with COAG known to have an allergy to preservatives 1st line tafluprost as Saflutan unit dose eye drops, 2nd line timolol preservative free, 3rd line dorzolamide as Trusopt unit dose eye drops preservative free

Treatment of advanced Chronic Open Angle Glaucoma (COAG)

- Consider surgery but in the interim treat with prostaglandin analogue and additional pharmacological treatment as required to achieve lowering of intra-ocular pressure

**Snippets of information**

- Tamsulosin is only licensed for use in BPH – but we are seeing it prescribed for women. Please note that this is an unlicensed use.
- Consultant prescription requests following private consultations should still follow the formulary. If they don't you should change the prescription to the formulary choice.
- Please do not supply home care delivery companies with retrospective prescriptions. All requests should be made prospectively before the goods are delivered to the patient.
- Colchicine should only be used short-term in acute gout (max 6mg per course ie 12 tablets) or during initial treatment with gout. Despite this, we are seeing large quantities on prescriptions eg 250,200,100 tablets. Please review and amend large quantities.
- Regulan has been discontinued. Prescribers are advised to use Fybogel as the most cost-effective alternative.

**Update on new medicines**

**Dabigatran for atrial fibrillation**

This remains low priority pending the publication of NICE Guidance and is not on the formulary. It should not be used unless exceptionality can be demonstrated to Priorities Panel on the usual proforma.

**Rivaroxaban**

This is expected to be marketed for AF in addition to its current license for thrombo-prophylaxis following hip and knee surgery. Like Dabigatran it should not be prescribed pending further guidance.

**Apixaban**

This is an alternative to Dabigatran and rivaroxaban but currently its use is limited to thrombo-prophylaxis.

**Roflumilast**

Roflumilast is licensed for use in moderate to severe COPD. The draft NICE Guidance notes that there was great uncertainty about the effect of roflumilast on reducing the rate of exacerbations as an add-on to triple or dual therapy for people with severe COPD. For that reason, the draft guidance recommends setting up a trial to assess its clinical effectiveness for this indication. We await NICE's final verdict on this medicine with interest. Currently it is not on the formulary and therefore should not be prescribed.

**Linagliptin**

This new gliptin for type 2 diabetes is not on the formulary and therefore should not be prescribed.

**Sticks and lancets for patients with Talking Blood Glucose Meters**

A few patients with visual impairment have talking blood glucose meters. It is not obvious from the practice systems which sticks and lancets can be prescribed to use with the meters. Thanks to Lesley Scott, Diabetes Specialist Nurse Education Facilitator for providing the answer: Sensocard Biosensor strips and Unilet general purpose superlite type A lancets 0.66/23gauge (Owen) which are universal fit for finger pricking devices.

**Tamoxifen interactions**
The MHRA has alerted prescribers to growing evidence that medicines that strongly inhibit the liver co-enzyme CYP2D6, including some SSRIs, may interact with tamoxifen, resulting in a poorer clinical outcome for women taking tamoxifen for breast cancer.

Concomitant use of medicines that are potent inhibitors of the CYP2D6 enzyme should therefore be avoided where-ever possible in patients treated with tamoxifen. These include
*Paroxetine, fluoxetine, bupropion, quinidine and cinacalcet.*

**Top Tips for GPs – Strategies for safer prescribing**
The National Prescribing Centre has published some top tips for GPs (and other prescribers). It can be found at: http://www.npc.nhs.uk/evidence/resources/10_top_tips_for_gps.pdf

This article, written by Professor Tony Avery, Professor of Primary Health Care, University of Nottingham Medical School, discusses medication errors and patient harm in primary care, including:

- which patients are most at risk from medication errors
- the drugs most commonly associated with preventable adverse events
- the underlying causes of medication errors and how can these be prevented practice points – 10 tips for safe prescribing

**European Antibiotic Awareness Day**
November 18th 2011 is the fourth European Antibiotic Awareness Day (EAAD). EAAD is supported in England by the Department of Health, the Health Protection Agency (HPA), GP, pharmacy and other allied healthcare professional bodies. This day aims to:

- Educate and inform patients and healthcare professionals about the appropriate use of antibiotics
- Motivate healthcare professionals to prescribe antibiotics more appropriately
- Educate and inform patients and healthcare professionals about the importance of preventing resistance to antibiotics

The two key messages for the public are:
**Coughs, colds - take care, not antibiotics.**
**Antibiotics- misuse them and you may lose them.**

Resources including patient information leaflets, fact sheets, and educational videos are available on the Department of Health website http://www.dh.gov.uk/health/2011/09/eaad/ or by contacting naomi.fleming@mkpct.nhs.uk. These materials can be used by all health care professionals to promote public awareness of the importance of prudent use of antibiotics. This is especially important in the winter which is the peak request and prescribing season for antibiotics.

**Unsolicited emails promoting medicines**
I have been contacted by one of our GPs after he received an unsolicited email promoting a new medicine. I had received and been irritated by the same email myself so it is possible that many of our readers had the same experience.

It seems that there is a data base confusingly called NHSDatabase that holds details of health professionals. According to its own website, “NHS database is the largest database of medical professionals employed within the NHS and private healthcare sectors in the UK. Registered users have free access to information on the site, including information about prescription only medicines and medical devices, which can only be directed to and accessed by healthcare professionals who prescribe these products. The site includes the latest information on the management of specific disease areas and medical conditions in an interactive format, including live online presentations and webcasts on the latest medical procedures.”

The pharmaceutical industry is permitted, through the ABPI Code of Practice, to distribute promotional emails to healthcare professionals (HCPs) as long as the individual HCP has given explicit permission to receive emails of this nature. However, many of us may be unaware that we had given permission. Much of the information will be available through other channels so if you wish to unsubscribe, contact Martin Seaton, Online Database Supervisor (**mseaton@nhsdatabase.com**), or alternatively phone him at 020 8457 7891 during office hours.

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