NHS
Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

October 2013

CCG Prescribing Group Meeting – 2nd October 2013

The main item for discussion was a review on prescribing carried out by the pharmacy team in light of increasing pressure on the prescribing budget which is currently forecast to over spend by about £2m. This is unprecedented in recent years.

Prescribing Group approved a number of initiatives including:-

- A switch programme
  - Dutasteride to Finasteride
  - Fentanyl to Matrifen
  - Melatonin specials to licensed product
  - Tadalafil and vardenafil to sildenafil
  - Venlafaxine capsules to tablets
- Limiting prescribing of over the counter products and those with limited clinical efficacy
- Capitalising on savings opportunities offered by ScriptSwitch
- Ensuring tight repeat prescribing systems and challenge over use / under use of prescribed medicines

Practices should have received a letter asking them to work with the neighbourhood pharmacists and wider team to deliver these cost savings. Please get in touch if you would like some help.

Milton Keynes Prescribing Advisory Group (MKPAG) – 25th September 2013

Key points from MKPAG were:-

- On-going discussion on rivaroxaban for DVT treatment and prophylaxis - currently the responsibility for prescribing is remaining with the hospital not the GPs.
- It was agreed that prescribing of ulipristal for uterine fibroids should remain with hospital consultants. GPs should not prescribe it for this indication.
- Metformin MR should only be used for appropriate patients not able to tolerate plain tablets following slow titration of the dose.
- Safety Issues – Ketoconazole has been removed from the formulary following advice from the MHRA
- Mirabegron remains hospital only until its place in therapy relative to agents such as tolterodine and oxybutinin has been agreed with the hospital consultants. Please refer requests to prescribe back to the specialists.
- Prescribing guidance for Asthma (patients over 18 years old) and for COPD including LAMA decision aid was approved and will be circulated soon.

The minutes of MKPAG meetings can be seen on the formulary website http://www.formularymk.nhs.uk/

Simvastatin dose and interactions

A year after the MHRA warning, we continue to see prescriptions for simvastatin 40mg with interacting medicines where the recommended dose is now 20mg. Please ensure that patients receiving simvastatin 40mg with any of the following are reviewed: - diltiazem, amlodipine, verapamil, ranolazine or amiodarone. Also, please remember that co-administration of simvastatin with gemfibrozil is contra –indicated.

Requests for ECGs and other tests prior to initiating medication

In the last edition we suggested that GPs should not undertake baseline ECGs or bloods prior to initiation and /or stabilisation of medication prescribed by secondary care clinicians. This prompted some debate with CNWL-MK Community Trust as, whilst accepting that this advice is correct in theory, it gives rise to some practical issues as not all their community clinics are able to take blood or do ECGs. Therefore they have asked for understanding from GPs and the CCG that there will be occasions where the GP is asked to carry out these tests. The service is investigating how it can undertake them in future.

Medicines to take abroad

At the request of some practices, the team has developed a leaflet to tell patients about their entitlement to medicines when they are going abroad. This can be found on the formulary website (see above for address).
The BMA recommends that doctors prescribe **no more than three months' supply** of medicines for patients not in the country, as per the current regulations, stating:
"The NHS accepts responsibility for supplying on-going medication for temporary periods abroad of up to 3 months. If a person is going to be abroad for more than three months then all that the patient is entitled to at NHS expense is a sufficient supply of his/her regular medication to get to the destination and find an alternative supply of that medication".

Pregnancy exclusion when prescribing oral retinoids

Although GPs do not usually prescribe isotretinoin (Roaccutane), they should be aware that hospital colleagues have decided to undertake two pregnancy tests in a woman to exclude the possibility of pregnancy before initiating therapy. Women of child bearing age must practice effective contraception and must also be registered with the pregnancy prevention programme in order to receive the medicine. Prescriptions will be limited to 30 days' supply at a time and dispensed within 7 days of the date of the prescription.

Antibiotics Update by Dr Naomi Fleming, Antibiotic Pharmacist CNWL-MK

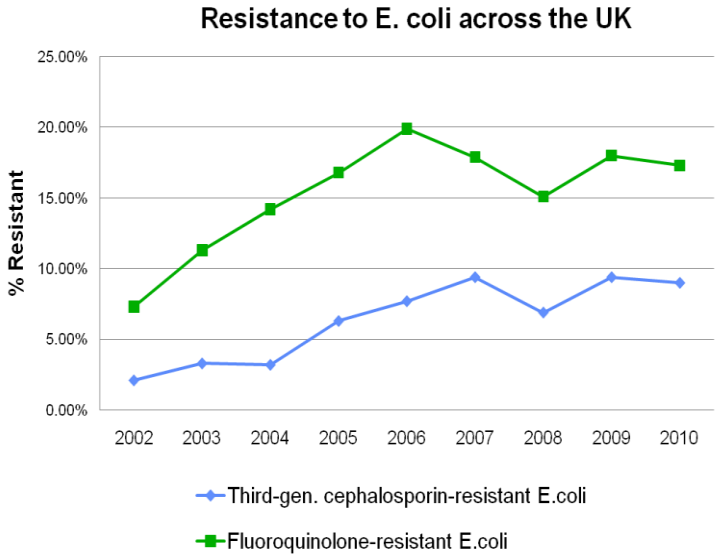
European Antibiotics Awareness Day is fast approaching (18th November) and practices may want to use this as an opportunity to do a display and tick a box in the PIS audit tool as part of their action plan.

Please visit the TARGET antibiotics website. The link below can be used to download posters, leaflets and quizzes for patients and staff. MK is represented among the case studies on this website.
https://www.gov.uk/government/publications/european-antibiotic-awareness-day-resources-for-primary-and-secondary-care

Training for the management of respiratory tract infections (MARTI) and Urinary Tract Infections (MUTs) is available free of charge via this website too.

A systematic review and meta-analysis by Costelloe et al reviewed the literature and found that studies reporting the quantity of antibiotic prescribed showed that longer duration and multiple courses were associated with higher rates of resistance. This effect not only increases the population carriage of organisms resistant to first line antibiotics, but also creates the conditions for increased use of second line antibiotics in the community. Reducing overall antibiotic prescribing, particularly when that antibiotic is not required, for example in coughs and colds will reduce the emergence of resistance.

Focus on the Urinary Tract:
Worryingly, the most common organism responsible for causing UTIs, *E.coli* is showing resistance to antibiotics used first and second line for UTIs including cephalosporins and quinolones.



Of particular concern is a strain of extended spectrum beta lactamase (ESBL) producing *E coli*. It produces a particular type of ESBL enzyme, CTX-M, which is able to break down a wide range of antibiotics. These strains were unrecorded in the UK prior to 2000. They have spread rapidly since 2003, causing UTIs in both hospital and community patients.

Most CTX-M-producing *E. coli* are resistant to multiple antibiotics including

- aminoglycosides, (eg gentamicin)
- fluoroquinolones (e.g. ciprofloxacin)
- trimethoprim
- most ß –lactams (these include penicillins and cephalosporins)

They remain susceptible to IV antibiotics such as the carbapenems and temocillin. Many are susceptible to the oral antibiotics nitrofurantoin and fosfomycin, both of which are only suitable for use in lower UTIs and the prescribing of nitrofurantoin and fosfomycin has increased locally across primary care. Serious infections require the use of broad spectrum IV antibiotics and this will increase the need to use parenteral antibiotics in the community setting, known as OPAT (Outpatient Parenteral Antibiotic Therapy).

Catheter Associated UTI -CAUTI:
The most effective way to reduce the incidence of CAUTI is to restrict the use of catheters to patients who have clear and documented indications for catheterisation, after all other appropriate strategies have been tried, and by removing the catheter as soon as it is no longer necessary. This should be the priority for all healthcare professionals.

It is important to only treat active symptomatic UTIs. Catheter colonisation or asymptomatic UTIs in the older person do not require antibiotic therapy and in fact treatment can cause harm to these patients (NNTH=3). These patients have a low rate of complications and treatment does not reduce subsequent CAUTI, but will increase antimicrobial resistance and adverse effects.

In patients with indwelling urethral, indwelling suprapubic or intermittent catheterization, CAUTI is defined by the presence of symptoms or signs compatible with a UTI with no other identified source of infection, along with $>10^3$ cfu/mL of one or more bacterial species in a single catheter urine specimen (correctly collected).

CAUTI should not routinely be screened for except in pregnant women or patients who undergo urologic procedures for which visible mucosal bleeding is anticipated.

Signs and symptoms compatible with CAUTI include:

- New onset or worsening fever
- Rigors
- Altered mental status/new onset delirium
- Malaise or lethargy with no other identified cause
- Flank pain
- Costovertebral angle tenderness
- Acute haematuria
- Pelvic discomfort
- Pyuria (i.e. leucocytes in the urine) is not diagnostic of CAUTI and is not an indication for antimicrobial treatment; however, the absence of pyuria in a symptomatic patient suggests a diagnosis other than CAUTI.

The presence of odorous or cloudy urine should not be used to diagnose CAUTI and is not an indication for urine culture or antimicrobial therapy.

In recurrent CAUTI, alternatives such as urinary sheaths for men, male and female urinals, incontinence pads or intermittent or suprapubic catheterisation, all of which reduce occurrence of CAUTI, can be explored by the assessing Healthcare Professional.

Contact the Continence Service for advice regarding the on-going need for catheterisation if not properly documented or catheter is due for review.

On-going/Recurrent UTIs:
It is important when assessing patients that other causes of urinary symptoms are taken into account, particularly if symptoms are on-going or recurrent. This can avoid the inappropriate use of antibiotics in patients, sometimes for months/years that may actually have a differing cause of their symptoms.

Men with problematic recurrent UTIs should be referred to secondary care to identify and manage possible underlying causes eg prostatitis, calculi, bladder or prostate cancer. There is no evidence to support antibiotic prophylaxis for recurrent UTI in men. If suffering an acute episode of UTI, he should be treated according to Empirical Guidance on the Management of Infection in Primary Care and an MSU sent for MC+S while waiting for referral. If the man is sexually active, screening for chlamydial infection is recommended. See also http://www.miltonkeynesccg.nhs.uk/gp-self-approval-policies/ for details of the MK LUTs in men policy.

In non-pregnant, non-catheterised women, always review diagnosis- culture urine to confirm infection and exclude other causes**.** Recurrent Urinary Tract Infection (UTI) is considered as two or more separate episodes of symptomatic UTI in six months or three or more in 12 months. An episode with treatment failure requiring a further course of antibiotics for the same episode is only counted once. It does not include asymptomatic bacteriuria in older people or people with catheters. If previous microbiological tests for an episode have come back as culture negative, the episode should not be included for consideration when diagnosing recurrent UTI and other causes should be investigated as in pathway above. The patient's medical and surgical history should be assessed for risk factors for recurrent cystitis e.g. stones, papillary necrosis and vesicoureteric reflux, this may require imaging and referral.

Refer urgently to secondary care if urological cancer is suspected, for example haematuria persists after successful treatment of previous acute UTI.

Further guidance on the management of UTI can be found at
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947404720

Information on Nitrofurantoin

MHRA alert August 2013 Nitrofurantoin: reminder on precautions for use, especially renal impairment in (elderly) patients:
The use of nitrofurantoin for urinary tract infections is contraindicated in patients with 60mL/min creatinine clearance. Healthcare professionals should be aware of a patient's current renal function when prescribing especially for elderly patients.
Please note that nitrofurantoin liquid is very expensive and unlicensed. Always check whether trimethoprim liquid would be a suitable alternative. Also please ensure when you prescribe 50mg nitrofurantoin it is capsules and not tablets as these are significantly more expensive.

More evidence about increased risk of pneumonia with high dose inhaled steroids

A Canadian study published in Thorax (http://thorax.bmj.com/content/68/11/1029.abstract) has provided extra evidence linking high dose inhaled corticosteroids with the risk of pneumonia. The authors reported that the risk is particularly elevated and dose related with fluticasone.

Current use of ICS was associated with a 69% increase in the rate of serious pneumonia (RR 1.69; 95% CI 1.63 to 1.75). The risk was sustained with long-term use and declined gradually after stopping ICS use, disappearing after 6 months (RR 1.08; 95% CI 0.99 to 1.17). The rate of serious pneumonia was higher with fluticasone (RR 2.01; 95% CI 1.93 to 2.10), increasing with the daily dose, but was much lower with budesonide (RR 1.17; 95% CI 1.09 to 1.26). Please ensure patient is able to use alternative device if you switch products.

Safe use of new oral anticoagulants

The MHRA has issued advice about the safe use of the new oral anticoagulants, dabigatran, rivaroxaban and apixaban. Unlike vitamin K antagonists, there is no need for routine monitoring of anticoagulant activity when administering these new medicines. However, clinical trials and post-marketing experience have shown that major bleeding events, including events leading to death, are not confined to vitamin K antagonists/LMWH but are also significant risks for the new oral anticoagulants. Furthermore, post-marketing reports indicate that not all prescribers are sufficiently aware of the product information in terms of managing bleeding risks.

Recommendations
In light of the above, prescribers should consider the individual patient risk of bleeding and observe posology, contraindications, and warnings and precautions for use. While differences in contraindications exist between the new oral anticoagulants, they share the following contraindications:

- Active clinically significant bleeding
- Lesion or condition, if considered a significant risk factor for major bleeding. This may include current or recent gastrointestinal ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities
- Concomitant treatment with any other anticoagulant agent e.g. unfractionated heparin (UFH), low molecular weight heparins (enoxaparin, dalteparin etc.), heparin derivatives (fondaparinux etc.), oral anticoagulants (warfarin, other) except under the circumstances of switching therapy to or from the medicine, or when UFH is given at doses necessary to maintain an open central venous or arterial catheter.

Please refer to the respective product information for Eliquis®, Pradaxa® and Xarelto® for information about additional contraindications specific to each medicine.

It is important to pay attention to the recommended posology and the warnings and precautions for use to minimise the risk of bleeding. This includes a careful benefit-risk assessment in patients with lesions, conditions, procedures and/or treatment (such as NSAIDs and antiplatelets), which increase the risk of major bleeding. In addition, clinical surveillance for signs and symptoms of bleedings is recommended throughout the treatment period, particularly in patients at increased risk of bleeding.

Attention should also be paid to renal function. Renal impairment may constitute a contraindication or a reason to consider not using the medicines or reducing their dose. Please refer to the product information since recommendations differ between the three medicines.

There is currently no specific antidote available for Eliquis®, Pradaxa® or Xarelto®. The product information for each product includes advice on treatment in the event of bleeding complications.

Healthcare professionals should report any adverse events suspected to be associated with the use of Eliquis®,

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744