NHS
Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

September 2014

CCG Prescribing Group Meeting 10th September 2014

The key points were:

- Breathlessness guidance has been uploaded onto the formulary website and can be found in the Respiratory chapter
- Just in Case bags / Anticipatory medicines was discussed – see below
- The revised national regulations on prescriptions for sildenafil were noted
- Flu PGDs have been sent out by the Area Team – please ensure you are on their distribution list.

Dr Wyke was thanked for her many years of input and support of the Prescribing Group. We wish her well in her retirement. If you would like to join the group please contact the Pharmaceutical Advisers to discuss.

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

Milton Keynes Prescribing Advisory Group (MKPAG) 24th September 2014

The key points were:

- Canagliflozin has been added onto the formulary as an option in line with NICE TA 315
- Clomiphene (Clomid) was added to the formulary. Please note that this should only be prescribed by secondary care specialists
- Ulipristal remains a hospital only drug and should not be prescribed in primary care
- The Pain Consultants have agreed to undertake a review of the place in therapy of strong opioids including Oxycodone and Tapentadol
- Optive Plus Eye Drops have replaced Optive drops on the formulary

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

Nitrofurantoin and other long term antibiotic therapy

The Pharmaceutical Advisers are aware of one local case of autoimmune hepatitis resulting from long-term treatment with nitrofurantoin and have been asked to draw this to the attention of prescribers. This is a rare adverse effect as is chronic and acute pulmonary toxicity.

The BNF advises prescribers to monitor liver function and pulmonary function and the Summary of Product Characteristics states that patients should be closely monitored for signs of hepatitis particularly in long term use.

All long term antibiotics should be reviewed every 6 to 12 months. The evidence of effectiveness from most trials is limited to 6 months. Beyond that, information on long-term use is lacking.

Recent MHRA advice:
Nitrofurantoin is now contraindicated in patients with an estimated glomerular filtration rate (eGFR) of less than **45 ml/min.** However, a short course (3 to 7 days) may be used with caution in certain patients with an eGFR of 30 to 44 ml/min. Only prescribe to such patients to treat lower urinary tract infection with suspected or proven multidrug resistant pathogens when the benefits of nitrofurantoin are considered to outweigh the risks of side effects. This contraindication allows nitrofurantoin to be used in patients for whom it was previously not recommended.
http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON452539

Switching from warfarin to a NOAC

There has been some confusion over whether it is necessary to give a loading dose when changing from warfarin to one of the new oral anticoagulants. It is only necessary to consider this with **rivaroxaban.** The other NOACs can be prescribed at their standard doses once the INR has fallen below 2.

The information on **rivaroxaban** from the manufacturer is as follows:-

For patients switching from warfarin to rivaroxaban for the treatment of acute DVT or PE and for continued prevention of recurrent DVT or PE, the dose of rivaroxaban would depend on the length of their previous anticoagulation therapy with alternative anticoagulants (before the switching of treatment).

For patients treated for DVT, PE and prevention of recurrence, if switching from warfarin to rivaroxaban, warfarin treatment should be stopped and rivaroxaban therapy should be initiated once the INR is ≤ 2.5. If a patient has been treated with warfarin therapy for 21 days or greater, they can be initiated on the **20 mg once daily** dose from day 22 of therapy.

If a patient has been treated with warfarin therapy for less than 21 days from initiation of anticoagulation, the patient should be initiated on rivaroxaban **15 mg twice daily until they have received a total of 3 weeks** anticoagulation therapy. After this initial 3 week period (from day 22), the patient may then be started on the **20 mg once daily** dosing regimen.

Domperidone: risks of cardiac side effects – indication restricted to nausea and vomiting, new contraindications, and reduced does and duration of use

Domperidone (Motilium) is associated with a small increased risk of serious cardiac side effects. Its use is now restricted to the relief of nausea and vomiting and the dosage and duration of use have been reduced. It should no longer be used for the treatment of bloating and heartburn.
Domperidone is now contraindicated in those with underlying cardiac conditions and other risk factors (see below). Patients with these conditions and patients receiving long-term treatment with domperidone should be reassessed at a routine appointment.

The MHRA has issued the following advice for healthcare professionals

Indication

- Domperidone is now restricted to use in the relief of nausea and vomiting
- It should be used at the lowest effective dose for the shortest possible time

Contraindications

- Domperidone is now contraindicated in people:
    - with conditions where cardiac conduction is, or could be, impaired
    - with underlying cardiac diseases such as congestive heart failure
    - receiving other medications known to prolong QT interval or potent CYP3A4 inhibitors
    - with severe hepatic impairment
- Patients with these conditions should have their treatment reviewed at their next routine appointment and be switched to an alternative treatment if required

Posology

Oral formulations

- For adults and adolescents over 12 years of age and weighing 35 kg or more, the recommended maximum dose in 24 hours is 30 milligrams (dose interval: 10 milligrams up to three times a day)
- In children under 12 years of age and weighing less than 35 kg, the recommended maximum dose in 24 hours is 0.75 mg/kg body weight (dose interval: 0.25 mg/kg body weight up to three times a day)

Suppository formulation

- Suppositories should only be used in adults and adolescents weighing 35 kg or more, the recommended maximum daily dose in 24 hours is 60 milligrams (dose interval: 30 milligrams twice a day)

Duration of treatment

- **The maximum treatment duration should not usually exceed one week**
- Patients currently receiving long-term treatment with domperidone should be reassessed at a routine appointment to advise on treatment continuation, dose change, or cessation

Administration of liquid formulations

- Oral liquid formulations of domperidone should only be given via appropriately designed, graduated measuring devices (e.g. oral syringes for children and cups for adults and adolescents) to ensure dose accuracy

Domperidone has been reclassified from 'P' to 'POM' - it no longer meets the requirements for supply with legal status 'P' (i.e. in a pharmacy without prescription, under the supervision of a pharmacist). From 4 September 2014, people taking domperidone to treat nausea and vomiting will only be able to get this medicine on prescription from their doctor. It will no longer be available from pharmacies without a prescription.

Guidance for healthcare professionals on drug driving

A new offence of driving with certain specified controlled drugs in excess of specified levels in the body is expected to come into force on 2 March 2015. This offence is an addition to the existing rules on drug impaired driving and fitness to drive. The legislation also provides for a statutory "medical defence" for this new offence, for patients taking their medicines in accordance with instructions.

In line with current professional practice, healthcare professionals prescribing or supplying medicines take account of the risks of medicines (such as whether a patient's driving may be impaired by their medicines) and advise accordingly. This clinical practice has not changed. However, healthcare professionals are likely to want to be able to explain the new rules concerning this offence to patients. The department for Transport guidance has been developed on the advice of independent clinical experts and has been approved by the Secretary of State's Honorary

Advisory Panel on Alcohol, Drugs and Substance Misuse. It is intended to assist healthcare professionals by clarifying key relevant information. For more information, please see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf?utm_medium=email&utm_source=Royal%20Pharmaceutical%20Society&utm_campaign=4378652_Department%20for%20Transport%20Guidance%20on%20Drug%20Driving&dm_i=EQ,2LUL8,817GI,9IQ89,1

Anticipatory Medicines towards the end of life

There have been a number of incidents recently relating to the timely provision of symptom control medicines. Good practice includes:

1. Consideration of how symptoms can be improved without using drugs
2. Common symptoms at the end of life are pain, agitation, nausea and vomiting, breathlessness, and respiratory secretions. Anticipatory prescribing for these symptoms will ensure that there is no delay in responding to the symptom when it occurs.
3. Assume that the oral route will not be possible, if not immediately, then in the near future and prescribe medications via the subcutaneous route pre-emptively.
4. Use water for injection as a diluent unless otherwise stated.
5. The prn dose of morphine is 1/6 of the total daily dose of morphine.
6. Where a patient already has FENTANYL or BUPRENORPHINE patches in situ, do not remove. Replace patch as required. Contact the Specialist Palliative Care Team for further guidance.
7. If the dying patient has renal failure, or Parkinson's disease, contact the Specialist Palliative Care Team for further guidance.
8. Symptoms can change frequently and rapidly. Regular assessment of the patient and reviewing the effect of interventions is crucial.

A template is available on SystmOne through the MKCCG templates section on the clinical tree to provide information and support prescribing.

Please do "think ahead" so that the patients and their families and carers have peace of mind regarding timely access to symptom control medicines.

Adrenaline auto-injector advice for patients:

The MHRA has advised that people who have been prescribed an adrenaline auto-injector because of the risk of anaphylaxis should carry two with them at all times for emergency, on-the-spot use. After every use of an adrenaline auto-injector, an ambulance should be called (even if symptoms are improving), the individual should lie down with their legs raised and, if at all possible, should not be left alone

Healthcare professionals should also:

- Ensure that people with allergies and their carers have been trained to use the particular auto-injector that they have been prescribed. Injection technique varies between injectors.
- Encourage people with allergies and their carers to obtain and practise using a trainer device (available for free from the manufacturers' websites).

Early childhood antibiotics and asthma risk

A study published in *Health News and Evidence* suggests an association between the use of antibiotics in early childhood and the development of asthma in the first 3 years of life. This association showed a dose–response relationship with an increased risk of asthma as the number of courses of antibiotics increased**.** While the new research adds to the existing body of evidence suggesting that reduced exposure to infection increases the risk of atopic conditions like asthma, a causal relationship is yet to be proven and needs further investigation. However, the study serves as a reminder of the importance of continued adherence to current antibiotic prescribing guidelines.

Practice points

- Continue to adhere to current guidelines when prescribing antibiotics for young children.
- Use microbiology results to guide your choice of antibiotic if possible.
- Prescribe the narrowest spectrum antibiotic required to treat the infection
- Prescribe the appropriate dose of antibiotic based on the location and type of infection.
- Keep the duration of antibiotic treatment to a minimum and be mindful that most minor bacterial infections are self-limiting.
- Using probiotics to prevent or treat asthma or transient wheeze in children is not supported by current evidence.

Significant scope to improve antibiotic prescribing

A new study by scientists at Public Health England (PHE) and University College London (UCL) has found that the likelihood of general practitioners (GPs) prescribing antibiotics for coughs and colds increased by 40% between 1999 and 2011, despite Government recommendations to reduce prescribing for illnesses largely caused by viruses.
The researchers also found that there was substantial variation in prescribing between general practices, with the highest prescribing practices twice as likely to give a prescription for coughs and colds as the lowest prescribers.
This research is published in today's Journal of Antimicrobial Chemotherapy.
Specific recommendations on better prescribing by GPs, first made by the Department of Health in 1998, and regularly updated by PHE and endorsed by the Royal College of General Practitioners include:

- no prescribing of antibiotics for simple coughs and colds
- no prescribing of antibiotics for viral sore throats
- limiting prescribing for uncomplicated cystitis to a 3 day course of antibiotics

Professor Jeremy Hawker, a consultant epidemiologist in the field epidemiology service at PHE, who led the study, said:

> "Although it would be inappropriate to say that all cases of coughs and colds or sore throats did not need antibiotics, our study strongly suggests that there is a need to make improvements in antibiotic prescribing. Previous research has shown that only 10% of sore throats and 20% of acute sinusitis benefit from antibiotic treatment, but the prescription rates we found were much higher than this. The worry is that patients who receive antibiotics when they are not needed run the risk of carrying antibiotic resistant bacteria in their gut. If these bacteria go on to cause an infection, antibiotics will then not work when the patient really does need them."

RCGP Chair Dr Maureen Baker said:

> "Antibiotics are very effective drugs, as long as they are used appropriately.
> But we have developed a worrying reliance on them and GPs face enormous pressure to prescribe them, even for minor symptoms which will get better on their own or can be treated effectively with other forms of medication.
> Our patients and the public need to be aware of the risks associated with inappropriate use of antibiotics and how to use them responsibly."

The researchers monitored trends in prescribing at 537 GP practices to assess whether treatment guidelines were being followed. The findings were as follows:

Coughs and colds

The proportion of patients who were prescribed an antibiotic by their GP for coughs and colds decreased from 47% in 1995 to 36% in 1999 but rose again to 51% by 2011. Strikingly, the researchers found marked variation between GP practices with some prescribing at twice the level of the lowest prescribing practices. The 10% of practices with the lowest prescribing rates prescribed antibiotics in less than a third of patients with cough and cold whereas the 10% of GP practices with the highest prescribing rates prescribed antibiotics to about 2-thirds of such patients.

Sore throats

Prescribing for sore throats fell from 77% in 1995 to 62% in 1999 and then stayed broadly stable. However, the data from 2011 showed that among those patients receiving an antibiotic, over 30% received an antibiotic that was not recommended in the national guidance. Once again there was significant variation between practices ranging from half to nearly 4 out of 5 patients with sore throats being prescribed an antibiotic.

Urinary tract infection (UTI)

Use of the recommended short course trimethoprim (the preferred antibiotic) in women aged 16 to 74 increased from 8% in 1995 to 50% in 2011. However, the between practice variation in prescribing of the recommended short course was very marked for this condition ranging from 16% or less to more than 70%.

Infection of the middle ear (otitis media)

Prescribing for this infection remained largely unchanged over the study period at 83% of cases. The study found that 10% of GP practices prescribed antibiotics to at least 97% of patients who presented with ear infections.

Prescriptions issued through EPS

Please note that if an EPS nominated pharmacy accepts a prescription through EPS it should undertake to supply the full amount of all the items on that prescription. If they cannot supply part of the prescription they should either print a token so the patient can have script dispensed elsewhere or undertake to obtain the missing item(s). They should not ask practices for additional prescriptions to separate off the item they cannot supply.

If problems persist, please contact your neighbourhood / practice pharmacist to discuss with the relevant community pharmacy.

Introduction of NRT Vouchers in Primary Care

The majority of NRT products have been added to the formulary and all are available for use in Primary Care. In order to simplify the prescription process for patients and reduce wasted product Stop Smoking Advisors in Primary Care will use an ***NRT Letter of Recommendation*** to Supply NRT (commonly known as a voucher) and ***not prescribe NRT on FP10.*** The Letters of Recommendation will be provided by the Stop Smoking Service directly to Advisors and it is planned that all NRT will be issued this from **1st October**. The majority of pharmacies across Milton Keynes have agreed to accept NRT Vouchers and already accept them. Details of these pharmacies will be provided to Advisors when they are issued with their vouchers.

Vouchers are issued **in 2/2/4/4/week blocks** to cover the maximum 12 weeks of product patients can receive on a quit attempt. Pharmacies will supply the product weekly to patients unless advisors inform them by way of a note on the voucher to do otherwise.

Advisors are asked to ensure they make a note on SystmOne of which products have been supplied for reference and to flag to other staff that the patient is on a quit attempt.

For more information, please contact Julia Banham, Stop Smoking Service Coordinator (Public Health)
Tel: 01908 254242 E: julia.banham@milton-keynes.gov.uk

Combination use of medicines from different classes of renin-angiotensin system blocking agents: risk of hyperkalaemia, hypotension and impaired renal function – new warnings

Combination use of medicines from different classes of renin-angiotensin system blocking agents is associated with an increased risk of hyperkalaemia, hypotension, and impaired renal function. New warnings have been agreed following an EU-wide review. In particular, prescribers are advised that people with diabetic nephropathy should not be given an ACE-inhibitor with an angiotensin-receptor blocker as they are already prone to developing hyperkalaemia. Combining aliskiren with an ACE-inhibitor or angiotensin-receptor blocker is contraindicated in people with kidney impairment or diabetes. Points to note include:-

- Combination use of medicines from two classes of RAS blocking agents (ACE-inhibitors, ARBs, or aliskiren) is not recommended.
- In particular, prescribers are advised not to give patients with diabetic nephropathy an ACE-inhibitor with an ARB since they are particularly prone to developing hyperkalaemia.
- The combination of aliskiren with an ACE-inhibitor or ARB is contraindicated in patients with kidney impairment or diabetes.
- Some patients with heart failure may have a medical need for treatment with an ACE-inhibitor and an ARB. Candesartan and valsartan are licensed as add-on therapy to ACE-inhibitors for people with symptomatic heart failure who require such a combination despite optimal therapy.
- The triple combination of an ACE-inhibitor, ARB, and a mineralocorticoid receptor antagonist or other potassium-sparing diuretic is not recommended.
- Patients currently taking a combination of RAS blocking agents should have their treatment reviewed. Carefully consider if combination use is appropriate.
- If combination use is considered absolutely necessary, it must be carried out under specialist supervision and with close monitoring of blood pressure, renal function, and electrolyte levels (particularly potassium). Consider monitoring patients when combination use is started and on a monthly basis thereafter, and also after changing dose and during intercurrent illness.

Headlice prescriptions

Please note that preparations for eradication of head lice are “low priority” and patents and carers should be encouraged to purchase them. If prescriptions are issued then the quantities per script should be per person not to treat a family.

Withdrawal of Inhaled Glucocorticoids and Exacerbations of COPD (New England Journal of Medicine September 8, 2014

Treatment with inhaled glucocorticoids in combination with long-acting bronchodilators is recommended in patients with frequent exacerbations of severe chronic obstructive pulmonary disease (COPD). However, the benefit of inhaled glucocorticoids in addition to two long-acting bronchodilators has not been fully explored.

In a 12-month, double-blind, parallel-group study, 2485 patients with a history of exacerbation of COPD received triple therapy consisting of tiotropium (at a dose of 18 µg once daily), salmeterol (50 µg twice daily), and the inhaled glucocorticoid fluticasone propionate (500 µg twice daily) during a 6-week run-in period. Patients were then randomly assigned to continued triple therapy or withdrawal of fluticasone in three steps over a 12-week period. The primary end point was the time to the first moderate or severe COPD exacerbation. Spirometric findings, health status, and dyspnoea were also monitored.

RESULTS As compared with continued glucocorticoid use, glucocorticoid withdrawal met the prespecified noninferiority criterion of 1.20 for the upper limit of the 95% confidence interval (CI) with respect to the first moderate

or severe COPD exacerbation (hazard ratio, 1.06; 95% CI, 0.94 to 1.19). At week 18, when glucocorticoid withdrawal was complete, the adjusted mean reduction from baseline in the trough forced expiratory volume in 1 second was 38 ml greater in the glucocorticoid-withdrawal group than in the glucocorticoid-continuation group (P<0.001); a similar between-group difference (43 ml) was seen at week 52 (P=0.001). No change in dyspnoea and minor changes in health status occurred in the glucocorticoid-withdrawal group.

CONCLUSIONS In patients with severe COPD receiving tiotropium plus salmeterol, the risk of moderate or severe exacerbations was similar among those who discontinued inhaled glucocorticoids and those who continued glucocorticoid therapy. However, there was a greater decrease in lung function during the final step of glucocorticoid withdrawal

The question of whether it is necessary to taper the glucocorticoid dose or simply withdraw treatment was not examined.

Changes to the status of sildenafil

Effective from August 1st 2014, generic sildenafil tablets 25, 50 and 100mg have been removed from Part XVIIIB of the *Drug Tariff* (known as the Selected List). As a result of this, prescribing of generic sildenafil on the NHS is no longer restricted to Selected List criteria, although all other pharmacological treatments for erectile dysfunction (ED) are still restricted in this way.

Selected List criteria are as follows:

- any man suffering from diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida or spinal cord injury
- any man receiving treatment for renal failure by dialysis
- any man who has had a prostatectomy or radical pelvic surgery or renal failure treated by transplant.
- any man who has been diagnosed as suffering severe distress resulting from erectile dysfunction where the assessment has been made by a specialist service or GP under arrangements made with a local Health Board to provide such assessments.

Recommendations:

- Prescribers should ensure that **generic sildenafil** tablets 25, 50 and 100mg tablets are always considered first line for the treatment of erectile dysfunction.
- Only patients that meet Selected List criteria can be considered for alternative treatments on the NHS (see above).
- Prescribers should review all arrangements for private prescribing of treatments for ED for patients who historically have not met the Selected List criteria. All of these patients should now be offered generic sildenafil tablets on NHS prescription; private prescribing of sildenafil tablets is no longer appropriate now that NHS restrictions have been lifted.
- Alternative erectile dysfunction treatments (including branded *Viagra*) can continue to be provided privately subject to patient preference.
- Prescribers should review their NHS prescribing of treatments for ED to ensure that patients who do not meet Selected List criteria are prescribed generic sildenafil 25, 50 and 100mg tablets.
- Loosening of national restrictions on generic sildenafil tablets now enables NHS prescribing of generic sildenafil for severe distress.
- Quantities guidance remains in force with a recommended dosage frequency of one dose per week; higher quantities can be prescribed at the discretion of the prescriber.
- All other formulations of sildenafil or brands remain under the control of Part XVIIIB of the *Drug Tariff* and can only be prescribed within that context.

2014/15 Prescribing Incentive Scheme – Prescribing Update Session

Hold the date and book your place!

The Update Session will be held on Thursday **22nd January 2015** at Heron's Lodge – lunch and registration from12.30pm with plans to run session from 1.00 till 3.30pm. Look out for further details coming soon meanwhile reserve your place via email to Sharon1.Wilmore@miltonkeynes.nhs.uk.

Systm1 Top tip: Warfarin Monitoring Data

There is a button that can be added to your toolbar on S1 called **"Warfarin monitoring data".** If this is pressed whilst in a patient on warfarin you can set the INR range relevant for that patient and its shows the INR in a graph and gives the TTR percentage.

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744