Midlands and Lancashire
Commissioning Support Unit

Tablets

Medicines Management News

Issue 26, May 2016

Wirral Medicines Guidelines Team

GUIDELINES

The following was discussed at the Medicines Clinical Guidelines Team (MCGT) in April 2016.

- Terms of Reference
- Drug allergy clinical guideline and penicillin allergy – for secondary care. Information to be adapted for use in Primary Care.
- Bacterial pneumonia in influenza – approved
- Upper GI/lower GI bleed pathway – approved
- Idarucizumab prescribing and administration guideline – approved
- Oral anticoagulant comparison table – approved pending minor amendments
- Acute pain management guidelines – approved
- Medicines and Falls in Hospital - approved
- Bleeding: Management in patients taking oral anticoagulants - approved
- DVT suspected investigational pathway – approved
- PE suspected investigational pathway – approved
- PE confirmed – management – approved
- Hypoglycaemia guideline – approved

Shared care guidelines:

- Melatonin – approved
- Atomoxetine – approved
- Methylphenidate – approved pending minor amendments
- Rasagiline for Parkinson's Disease – approved

- Rotigotine for Parkinson's Disease – approved
- Cardiology chapter – approved, pending minor amendment

Any guidelines or shared care guidelines relevant to Primary Care will be published on the Medicines Management website in due course.

Safety

MHRA DRUG SAFETY UPDATE

△ Paraffin-based skin emollients on dressings or clothing: fire risk

Smoking or a naked flame could cause patients' dressings or clothing to catch fire when being treated with a paraffin-based emollient that is in contact with the dressing or clothing.

A recent fatal incident has been reported to the NHS England National Reporting and Learning System, in which a naked flame ignited emollient in contact with a patient's dressings and clothing.

A reminder for healthcare professionals:

> Advise patients not to: smoke, use naked flames (or be near people who are smoking or using naked flames), or go near anything that may cause a fire, while emollients are in contact with their medical dressings or clothing.
>
> Advise patients to change their clothing and bedding regularly, preferably daily, because emollients soak into fabric and can become a fire hazard.
>
> Report any incident to NHS England.

An information poster is available from the National Patient Safety Agency. This can be found in the link below.

https://www.gov.uk/drug-safety-update/paraffin-based-skin-emollients-on-dressings-or-clothing-fire-risk

△ Trametinib (Mekinist®▼): risk of gastrointestinal perforation and colitis

Use trametinib, authorised either as monotherapy or combined with dabrafenib, with caution in patients with risk factors for gastrointestinal perforation, such as gastrointestinal metastases or diverticulitis, or use of concomitant medicines that can cause gastrointestinal perforation.

https://www.gov.uk/drug-safety-update/trametinib-mekinist-risk-of-gastrointestinal-perforation-and-colitis

△ Live attenuated vaccines: avoid use in those who are clinically immunosuppressed

Healthcare professionals working in Primary and Secondary Care should ensure that clinically significant immunosuppression in a patient is identified before administration of a live attenuated vaccine.
Live attenuated vaccines should not routinely be given to people who are clinically immunosuppressed (either due to drug treatment or underlying illness).
It is important for healthcare professionals who are administering a particular vaccine to be familiar with the contraindications and special precautions before proceeding with immunisation.
Specialists with responsibility for an immunosuppressed patient who may be in a group eligible for a live attenuated vaccine should include in their correspondence with Primary Care a statement of their opinion on the patient's suitability for the vaccine.

If Primary Care professionals are in any doubt as to whether a person due to receive a live attenuated vaccine may be immunosuppressed at the time, immunisation should be deferred until Secondary Care specialist advice has been sought, including advice from an Immunologist if required.
Remember that close contacts of immunosuppressed individuals should be fully immunised to minimise the risk of infection from vaccine-preventable diseases in immunosuppressed individuals.

https://www.gov.uk/drug-safety-update/live-attenuated-vaccines-avoid-use-in-those-who-are-clinically-immunosuppressed

△ Meprobamate: licence to be cancelled

Following an EU-wide review of meprobamate, the remaining licence holder in the UK has ceased manufacturing and the licence will be cancelled by the end of 2016.

https://www.gov.uk/drug-safety-update/meprobamate-licence-to-be-cancelled

△ Natalizumab (Tysabri®▼): progressive multifocal leukoencephalopathy - updated advice to support early detection

Perform a quantitative serum anti-JCV antibody test, including index value, to support risk stratification for progressive multifocal leukoencephalopathy. For high-risk patients, consider more frequent MRI screening.

https://www.gov.uk/drug-safety-update/natalizumab-tysabri-progressive-multifocal-leukoencephalopathy-updated-advice-to-support-early-detection

△ Dimethyl fumarate (Tecfidera®): updated advice on risk of progressive multifocal leukoencephalopathy

Cases of progressive multifocal leukoencephalopathy have been reported in patients taking dimethyl fumarate for multiple sclerosis, who all had prolonged lymphopenia.

https://www.gov.uk/drug-safety-update/dimethyl-fumarate-tecfidera-updated-advice-on-risk-of-progressive-multifocal-leukoencephalopathy

△ Fingolimod (Gilenya®▼): risks of progressive multifocal leukoencephalopathy, basal-cell carcinoma and opportunistic infections

The immunomodulatory effects of fingolimod increase the risk of progressive multifocal leukoencephalopathy and opportunistic infections.

https://www.gov.uk/drug-safety-update/fingolimod-gilenya-risks-of-progressive-multifocal-leukoencephalopathy-basal-cell-carcinoma-and-opportunistic-infections

△ Aflibercept (Zaltrap®▼): minimising the risk of osteonecrosis of the jaw

Cases of osteonecrosis of the jaw (ONJ) have been reported in patients with cancer who have been treated with aflibercept (Zaltrap®▼). Patients who have also previously or concomitantly received an intravenous bisphosphonate may be at particular risk. Before starting treatment, consider whether a dental examination and any appropriate preventive dentistry are needed.
Avoid invasive dental procedures, where possible, in patients being treated with Zaltrap®▼ who have previously received, or are currently receiving, an intravenous bisphosphonate. During treatment, advise patients to: maintain good oral hygiene; receive routine dental check-ups; and to report any oral symptoms such as dental mobility, pain, or swelling.
Suspected adverse reactions should be reported on a Yellow Card.

https://www.gov.uk/drug-safety-update/aflibercept-zaltrap-minimising-the-risk-of-osteonecrosis-of-the-jaw

⚠ Apomorphine with domperidone: minimising risk of cardiac side effects

Before starting treatment, carefully consider whether the benefits of concomitant apomorphine and domperidone treatment outweigh the small increased risk of cardiac side effects.

Discuss the benefits and risks of apomorphine with patients and carers, and advise them to contact their doctor immediately if they develop palpitations or syncopal symptoms during treatment.

Check the QT-interval before starting domperidone, during the apomorphine initiation phase and if clinically indicated thereafter (e.g. if a QT-prolonging or interacting drug is started or if symptoms of cardiac side effects are reported).

Regularly review domperidone treatment to ensure patients take the lowest effective dose for the shortest duration.

Advise patients to inform their doctor of any changes that could increase their risk of arrhythmia, such as symptoms of cardiac or hepatic disorders, conditions that could cause electrolyte disturbances (e.g. gastroenteritis or starting a diuretic) or starting any other medicines.

Please continue to report suspected side effects to apomorphine, domperidone or any other medicine on a Yellow Card.

https://www.gov.uk/drug-safety-update/apomorphine-with-domperidone-minimising-risk-of-cardiac-side-effects

⚠ SGLT2 inhibitors: updated advice on the risk of diabetic ketoacidosis

Test for raised ketones in patients with ketoacidosis symptoms, even if plasma glucose levels are near normal.

When treating patients who are taking a sodium-glucose co-transporter 2 (SGLT2) inhibitor (canagliflozin, dapagliflozin, or empagliflozin):

- inform patients of the signs and symptoms of diabetic ketoacidosis (DKA) – see link below – and advise them to seek immediate medical advice if they develop any of these
- discuss the risk factors for DKA with patients
- discontinue treatment with the SGLT2 inhibitor immediately if DKA is suspected or diagnosed
- do not restart treatment with any SGLT2 inhibitor in patients who experienced DKA during use, unless another cause for DKA was identified and resolved
- interrupt treatment with the SGLT2 inhibitor in patients who are hospitalised for major surgery or acute serious illnesses; treatment may be restarted once the patient's condition has stabilised
- report suspected side effects to SGLT2 inhibitors or any other medicines on a Yellow Card.

https://www.gov.uk/drug-safety-update/sglt2-inhibitors-updated-advice-on-the-risk-of-diabetic-ketoacidosis

Current Issues

NEWS

Interface reporting

The Q4 2015-16 interface report is now available to view on the Medicines Management website:
http://mm.wirral.nhs.uk/hospitalconcerns/
It provides details of concerns GPs have submitted regarding hospital prescribing in Q4.

Doxazosin modified release (MR) tablets - patient safety incident

A Wirral practice have recently identified that they were prescribing doxazosin MR 16mg daily for a patient. This had been recommended by a Cardiologist as doxazosin 16mg daily, but the MR preparation had been prescribed at the 16mg dose. The maximum licensed dose of doxazosin immediate release is 16mg daily, but the maximum licensed dose of doxazosin MR is 8mg daily.

The Medicines Management Team is currently reviewing patients on doxazosin MR with a view to switching to doxazosin immediate release, as this is more cost effective therapy option. For practices that have signed up to this work, patients being prescribed unlicensed doses of doxazosin MR will be identified and highlighted to the GP, as part of this review. For other practices, it is recommended that practices identify any patients on unlicensed doses of doxazosin MR for GP review.

ScriptSwitch messages will also be updated to further support prescribers.

NSAIDs for chickenpox

A reminder has been issued to pharmacists regarding the use of ibuprofen in children with chickenpox. In these children NSAIDs can increase the risk of necrotizing soft-tissue infections and secondary infections caused by invasive streptococci. The warning to avoid ibuprofen in children with chickenpox is included in national guidance on chickenpox but is not included in patient information leaflets or summaries of product characteristics for all ibuprofen products.
https://www.npa.co.uk/news-and-events/news-item/use-nsaids-children-chickenpox/

ISO Standards for Blood Glucose Meters for Patient Use

ISO standards for blood glucose meters for patient use[1]

A revised set of quality standards for blood glucose monitoring was published in May 2013 (ISO 15197:2013) to ensure accuracy and consistency of blood glucose results for people with diabetes.

The transition period for implementation of these standards by meter manufacturers will end in **May 2016**. As a result, some meter systems will be non-compliant with the new standard, and test strips for these meters will become unavailable.

Healthcare professionals are advised to check and if necessary, upgrade patients to compliant meter systems. **Note: all meters in the Wirral Blood Glucose Monitoring at Home Guideline are compliant with ISO 15197:2013**[2]**.**

References

1. Changes to ISO 15197: 2013 Standards for Blood Glucose Monitoring. Letter to Healthcare Professionals. BIVDA (British In Vitro Diagnostics Association) April 2016
2. Blood glucose test strip evaluation protocol and results. Greater Manchester Medicines Management Group v3.0 December 2015

Topics of the Month

WORLD HYPERTENSION DAY 17TH MAY 2016

Know your blood pressure!

Globally, increased blood pressure is the leading cause of deaths and disability. An estimated 18% of deaths (9.4 million) and 162 million years of life lost were attributed to increased blood pressure in 2010. Approximately 4 in 10 adults over age 25 have hypertension and in many countries another 1 in 5 has prehypertension. One half of blood pressure-related disease occurs in people with higher levels of blood pressure even within the normal range. Hypertension now disproportionately impacts low- and middle-income countries.

Estimates suggest that around 50% of hypertension is related to an unhealthy diet (30% related to increased salt consumption and 20% related to low dietary potassium-low fruit and vegetable intake). Physical inactivity is related to about 20% of hypertension and obesity is related to about 30% of hypertension. Excess alcohol and fat consumption also causes hypertension. Being tobacco free is especially important for people with hypertension. The United Nations has agreed to a 2025 goal of reducing hypertension by 25% and dietary sodium 30%. The World Hypertension League aims to work with national hypertension organisations, and governmental and non-governmental partners to help achieve the United Nations Targets.

Reference: International Society of Hypertension: http://ish-world.com/events/e/World-Hypertension-Day-2016/

Pharmacological treatment and choice of antihypertensive

Use in conjunction with treatment steps	Age < 55 years	Age > 55 years and black people of African/Caribbean descent of any age
1	A	C
2	A + C	
3	A + C + D	
4	Resistant hypertension A + C + D + additional diuretic or alpha-blocker or beta-blocker Consider seeking specialist advice	

A = ACE inhibitor (ramipril or lisinopril) or low cost ARB (losartan)
C = Calcium-channel blocker (amlodipine)
D = Thiazide-like diuretic (indapamide 2.5mg)

Give patients with isolated systolic hypertension (systolic BP ≥160 mmHg) the same treatment as patients with both raised systolic and diastolic BP. For patients >80 years, give the same treatment as patients aged ≥55 years. Take account of any comorbidity and concurrent drugs.

Prescribe:

- Drugs taken once a day if possible.
- Generic drugs where appropriate, to minimise cost.

ACEI and ARB

- If an ACEI is not tolerated, prescribe a low cost ARB.
- **Do NOT** combine an ACEI with an ARB.

Diuretics

- Bendroflumethiazide or hydrochlorothiazide are no longer recommended as diuretics for hypertension.
- If a diuretic is started or changed, prescribe
    - chlortalidone 12.5mg to 25mg once daily, **or**
    - indapamide 2.5mg once daily.
- For people already taking bendroflumethiazide or hydrochlorothiazide whose BP is stable, continue treatment.
- Use spironolactone with caution in patients with a reduced eGFR due to the increased risk of hyperkalaemia.

Calcium channel blockers

- CCBs are now the preferred treatment option at step 2 as they are cost effective.
- If a patient needs a second drug, add a CCB rather than a thiazide-like diuretic, to reduce the risk of developing diabetes.

Reference: NICE Bites:
http://www.medicinesresources.nhs.uk/upload/documents/Health%20In%20Focus/NICE_Bites_Sept2011.pdf

Wirral Hypertension guidelines and Hypertension guidelines for pregnancy can be found at:

http://mm.wirral.nhs.uk/guidelines/

COELIAC DISEASE AWARENESS WEEK 9TH TO 15TH MAY 2016

1% of the UK population has coeliac disease, but only 24% of those with the condition are medically diagnosed. This means that half a million people in the UK are living with undiagnosed coeliac disease.

Coeliac UK will be highlighting the most commonly reported symptoms of the condition, with a range of initiatives. The Awareness Week is a push to improve diagnosis and to empower more people to ask themselves 'Is it coeliac disease?'

Campaign aims

The campaign hopes to put people who are suffering with the symptoms of coeliac disease on a pathway to diagnosis, so they can be properly supported to manage their condition and avoid long-term health complications.

The campaign aims to halve the length of time to confirm a diagnosis, which is currently on average 13 years. It also aims to reduce misdiagnosis of irritable bowel syndrome (IBS) by 50%.

The long-term goal is to confirm a diagnosis for an additional 250,000 people by 2020, so that these people are freed from not knowing what is causing their symptoms.

Wirral CCG Gluten-free foods prescribing policy can be found at: http://mm.wirral.nhs.uk/prescribingpolicies/

Further information from Coeliac UK: https://www.coeliac.org.uk/get-involved/awareness-week-2016-is-it-coeliac-disease/

References: https://www.coeliac.org.uk/home/

Drug Tariff

DRUG AVAILABILITY

Medication supply issues

The following generic drugs have supply issues and hence are incurring increased costs. They have been given a NCSO (NO CHEAPER STOCK OBTAINABLE) status for April 2016. Please consider the costs of the following drugs before prescribing.

Product	Quantity	Price concession
Bumetanide 1mg tablets (new)	28	£2.50
Celiprolol 400mg tablets	28	£39.65
Cimetidine 400mg tablets	60	£19.99
Desmopressin 10micrograms/dose nasal spray (new)	60 dose	£24.00
Flecainide 50mg tablets	60	£7.50
Flecainide 100mg tablets	60	£6.83
Fludrocortisone 100mcg tablets (new)	100	£96.00
Lamotrigine 5mg dispersible tablets sugar free	28	£7.50
Mefenamic acid 500mg tablets	28	£10.25
Nitrofurantoin 100mg tablets (new)*	28	£12.50
Nitrofurantoin 50mg tablets (new)*	28	£11.50
Pioglitazone 15mg tablets	28	£19.20
Pioglitazone 30mg tablets	28	£24.32

*Nitrofurantoin 100mg modified release capsules are the most cost effective formulation at the current time

Other drugs with long-term supply issues

The following drugs have long-term supply issues. The table below shows the reason for the supply issue, where known, and possible return to stock dates.

Item	Status	More information
Aromasin® 25mg tablets	No availability date	Prescribe generically as exemestane 25mg tablets
Cardura® Xl 8mg tablets	No availability date	Prescribe as immediate release doxazosin 4mg tablets
Codipar® 15 mg/500 mg capsules	No availability date	Prescribed as codeine 15mg tablets and paracetamol caplets/capsules

		separately
Erythroped A® 500mg tablets	Due August 2016	Prescribe as erythromycin 250mg tablets
Evorel Sequi® patches	Limited supply	
Kwells® 300 microgram tablets x 12	No availability date	
Nozinan® ampoules 25mg/ml 1ml x 10	Due July 2016	If used as an antiemetic in palliative care haloperidol 5mg/1ml injection is an alternative
Pred Forte® 1% eye drops x 5ml	Due June 2016	Prescribe as a 10ml pack size
Premique® low dose tablets 0.3mg/4.5mg 28 x 3	Limited supplies ongoing	Medical Information Enquiries - 0845 608 8866
Sno Tears® x 10ml	No availability date	
Traxam® Gel 3% x 100g	No availability date	
Univer® Cap 120mg and 240mg capsules x 28	Due July 2016	Alternatives include Half Securon SR® and Securon SR® tablets
Xailin® Gel 0.2% x 10g	No availability date	
Zomig® Nasal Spray 5mg 2x3	No availability date	Prescribe generically as sumatriptan 10mg/dose nasal spray

Availability can vary geographically and also between wholesalers. Up-to-date information should be sought from manufacturers, local community pharmacies and suppliers. For any further information regarding supply problems please contact the Medicines Enquiry Service on 0151 541 5400.

Nadolol (Corgard®) discontinued by manufacturer for commercial reasons

Nadolol is a beta blocker licensed for use in hypertension, angina, arrhythmias, migraine prophylaxis and adjunctive treatment of thyrotoxicosis. Supply chain stock will be limited and there is no generic alternative. Treatment should not be stopped abruptly and therefore patients who are currently being prescribed nadolol should be identified, reviewed and offered an appropriate alternative.

Any patients who are under or have been under Cardiology at Alder Hey Hospital (for congenital heart disease or arrhythmias, e.g. SVT or prolonged QT syndrome), who are stable on treatment with nadolol should continue with this treatment, as children with arrhythmias can be very difficult to control. It is possible to import nadolol and the following alternative suppliers have been identified:

- Mawdsleys can import nadolol 40mg tablets from Canada. 100 tablets cost £60.38. Stock will be available from end of April 2016
- UL Medicines are looking at importing nadolol (Corgard®) 80mg tablets from France. A 28 tablet pack costs £6.63. This is anticipated to be available in 4-6 weeks' time.

Top ten monthly price reductions

Carbimazole 20mg tablets [1 x 100] £218.85 (-£43.07)
Nortriptyline 25mg tablets [1 x 100] £71.67 (-£29.46)
Carbimazole 5mg tablets [1 x 100] £87.51 (-£21.10)
Selegiline 10mg tablets [1 x 30] £9.50 (-£15.45)
Aripiprazole 10mg tablets [1 x 28] £6.42 (-£14.39)
Aripiprazole 5mg tablets [1 x 28] £6.42 (-£14.21)
Aripiprazole 15mg tablets [1 x 28] £6.35 (-£13.89)
Trospium chloride 20mg tablets [1 x 60] £5.78 (-£12.57)
Selegiline 5mg tablets [1 x 60] £15.37 (-£10.88)
Metronidazole 200mg tablets [1 x 21] £1.55 (-£10.11)

Top ten monthly price increases

Trazodone 50mg/5ml oral solution sugar free [1 x 120] £153.42 (+£78.74)
Olsalazine 500mg tablets [1 x 60] £161.00 (+£76.00)
Nitrofurantoin 25mg/5ml oral suspension sugar free [1 x 300] £446.95 (+£74.49)
Olsalazine 250mg capsules [1 x 112] £144.00 (+£69.00)
Liothyronine 20microgram tablets [1 x 28] £258.20 (+£59.58)
Pioglitazone 45mg tablets [1 x 28] £33.81 (+£32.34)
Trimipramine 25mg tablets [1 x 28] £136.10 (+£32.18)
Trimipramine 10mg tablets [1 x 28] £121.94 (+£27.91)
Alimemazine 30mg/5ml oral solution [1 x 100] £156.05 (+£24.02)
Trimipramine 50mg capsules [1 x 28] £110.00 (+£20.00)

Top 100 annual price increases

http://www.panmerseyapc.nhs.uk/home/tariff_watch/partviiia_increases_201604.pdf

Top 100 annual price reductions

http://www.panmerseyapc.nhs.uk/home/tariff_watch/partviiia_reductions_201604.pdf

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