NORTHERN IRELAND MEDICINES MANAGEMENT

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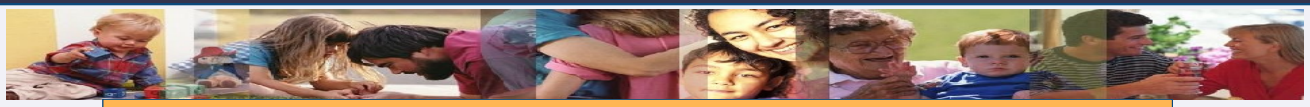
Health and Social Care Board

NEWSLETTER



In This Issue

NEW!

Updated NI Wound Care Formulary now available online.
Hard copies will be available hot off the press soon!

Urinary Incontinence (UI) in Dementia

Older adults are likely to have multiple medical conditions which can lead to therapeutic dilemmas. For example, two common medical conditions; dementia and urinary incontinence (UI) often coexist.

Issues to consider

- Almost invariably, the person with dementia will develop incontinence as the disease progresses.
- There are many causes for UI and among the elderly with dementia the problem is often not related to abnormalities of the lower urinary tract and can be described as 'functional' rather than 'urge'.
- Treatment options for urge UI (such as bladder anticholinergics) are limited by the multiple comorbidities, cognitive issues, medication side effects and limited efficacy (particularly in functional UI).
- Side effects of Cholinesterase inhibitors (ChIs), commonly used to treat dementia include urinary frequency or incontinence. As a consequence patients treated with ChIs are at an increased risk of receiving an anticholinergic drug to manage UI.

Drug therapy dilemma

Cholinesterase Inhibitors, commonly prescribed to treat dementia, reduce the rates of cognitive and functional decline by increasing acetylcholine levels at brain synapses.

Bladder anticholinergics commonly prescribed to treat UI typically act on muscarinic receptors to decrease acetylcholine effect by blocking it's action

Thus, *anticholinergics and cholinesterase inhibitors are in pharmacological opposition*, and the simultaneous pharmacological treatment of dementia and UI could lead to reduced effectiveness of one or both drugs.

Bladder anticholinergics include Darifenicin, Fesoterodine, Flavoxate, Oxybutynin, Propiverine, Solifenicin, Tolterodine and Trospium.

Cholinesterase inhibitors include Donepezil, Galantamine and Rivastigmine

Actions for GP practices

- Search clinical system for patients co-prescribed bladder anticholinergics and cholinesterase inhibitors.
- Prioritise these patients for medication review.
- Consider a 'drug holiday' or stopping bladder anticholinergic drug. Involve the patient or carer in the decision and refer to continence team for non-pharmacological coping strategies as appropriate.
- Explain the possible long term effects of anticholinergic medicines on cognitive function.
- Consider other medicines which might be contributing to UI*.

When a patient presents with cognitive decline, specialists would advise that their anticholinergic medicines are reviewed before referral to secondary care for potential dementia diagnosis.

Specialists would also consider it appropriate to review and deprescribe the Cholinesterase inhibitor (carefully and gradually) in patients at a very advanced stage in their dementia process if it is no longer felt to be effective or appropriate.

Actions for Community Pharmacists

- Where appropriate, offer advice and support to patients undergoing review of their UI medication.
- When a cholinesterase inhibitor is co-prescribed with a bladder anticholinergic highlight to the patient's GP that review of this combination is recommended.

*Diuretics, clozapine, alpha adrenoreceptor antagonists, calcium channel antagonists, SSRIs, SGLT2 inhibitors

Recent incidents with Ethinylestradiol

Incident One:
Patient on ethinylestradiol 20 micrograms / norethisterone 1mg oral contraceptive attended for review. Ethinylestradiol 2 micrograms was selected in error and issued to the patient.

Incident Two:
Ethinylestradiol 2mg, instead of 2micrograms, was prescribed for a paediatric patient for pubertal induction. This occurred because:

- The 2 microgram strength could not be found on the computer so it was assumed that 2 mg was intended.
- There was potential confusion between the two drugs ethinylestradiol and estradiol.The prescriber was familiar with using 'estradiol 2mg' for menopausal women and considered 'ethinylestradiol 2mg' to be similar.

'Ethinylestradiol' and 'estradiol' are not the same and have different indications and dosage regimens.
Ethinylestradiol should **never** be prescribed as a sole agent for contraceptive purposes – **see table.**

Drug*	Available preparations	Indications
Ethinylestradiol (a synthetic oestrogen) *As a sole agent*	10microgram, 50microgram and 1mg Licensed products	Female hypogonadism. Menstrual disorders. Palliative treatment of prostate cancer. Symptoms of oestrogen deficiency and osteoporosis prophylaxis. Priming prior to growth hormone stimulation test (3 day course)
	2microgram tablets Unlicensed	**Induction and maintenance of sexual maturation in girls (initiated by specialist)**
Ethinylestradiol *in combination with a progestogen*	Various hormonal contraceptives refer to BNF	Hormonal contraception Menstrual symptoms
Estradiol (a natural oestrogen) *As a sole agent or in combination with a progestogen*	Various HRT and contraceptive preparations refer to BNF	Hormonal contraception Menopausal symptoms and osteoporosis prophylaxis.

Action for Prescribers

- If the required medication or strength cannot be found on the clinical system it should never be assumed that a different item was intended. When dosages are required as 'micrograms', the full term should be written, i.e. micrograms not 'mcgs'
- Ethinylestradiol and estradiol and their various strengths must not be confused or used interchangeably.
- Ensure that the drug and strength selected are clinically appropriate for the patient and their indication.
- Combined oral contraceptives and HRT must be prescribed by brand. http://niformulary.hscni.net/PrescribingNewsletters/PDF/GenericsBulletin/Generics%20exception%20list%20January%202019.pdf

Action for Community Pharmacists

- Query changes to medication or unusual prescribing, identified as part of the clinical check with the patient/ prescriber, as appropriate
- Highlight to prescriber any combined product that has not been prescribed by brand.

NICE GUIDANCE — NORTHERN IRELAND SERVICE NOTIFICATIONS

Service Notifications have been issued in Northern Ireland for the following:
TA 599 Sodium zirconium cyclosilicate for treating hyperkalaemia

MANAGED ENTRY DECISIONS

Atezolizumab (Tecentriq®)
Cannabidiol (Epidyolex®)
Ceftolozane + tazobactam (Zerbaxa®)
Cerliponase alfa (Brineura®)
Cladribine (Mavenclad®)
Fluocinolone acetonide (Iluvien®)
Glecaprevir + pibrentasvir (Maviret®)
Ibrutinib (Imbruvica®)
Lusutrombopag (Mulpleo®)
Neratinib (Nerlynx®)
Olaparib (Lynparza®)
Palbociclib (Ibrance®)
Patiromer (Veltassa®)
Prasterone (Intarosa®)
Ramucirumab (Cyramza®)
Ruxolitinib (Jakavi®)
Sotagliflozin (Zynquista®)
Trientine tetrahydrochloride (new formul.)Cuprior®)
Zanamivir (Dectova®)

The following medicines were considered in August as part of the Northern Ireland Managed Entry process. **Please refer to the Managed Entry section of the Northern Ireland Formulary website for full details on Managed Entry**

This newsletter has been produced for GPs and pharmacists by the Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents of this newsletter, please contact one of the Pharmacy Advisors in your local HSCB office:
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