NORTHERN IRELAND MEDICINES MANAGEMENT

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Health and Social Care Board

NEWSLETTER

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Risky Opioid Combinations

The MHRA issued a Drug Safety Update in March 2020 on the risk of potentially fatal respiratory depression when benzodiazepines and opioids are combined.

New data published showed that in 2018 there were 115 deaths in Northern Ireland involving an opioid – an increase of over 200% in the past ten years. Risks associated with opioids are increased when they are co-prescribed with certain drugs, as shown in the table.

High Risk Opioid Combinations - Common Examples*	
Opioid plus	**Background**
Pregabalin or gabapentin	Gabapentin and pregabalin can cause central nervous system depression, resulting in drowsiness, sedation, and potentially fatal respiratory depression, particularly if co-prescribed with opioids (which also cause CNS depression).
Benzodiazepines	Several studies have shown an increased risk of harm and death in patients co-prescribed opioids and benzodiazepines, as a result of their combined CNS depressant effects.
Tricyclic antidepressants, e.g. amitriptyline	Following a patient death due to an interaction between amitriptyline and oxycodone, a coroner has highlighted the increased risk of over-sedation and serotonin syndrome when opioids are used in combination with tricyclic antidepressants
Other sedating medicines, e.g. z drugs	Caution is needed as risks are increased by the additive sedating effects.
***Do not prescribe more than one opioid on a regular basis for chronic pain**	

Risks are increased further by factors such as:

- Higher doses
- Number of risky drug or alcohol combinations
- Increasing age
- Co-morbidities, e.g. respiratory disease, dementia
- Concomitant OTC opioids
- History of self-harm / overdose

Action for GP practices:

- Think twice before prescribing high risk opioid combinations.
- Prioritise patients on high risk opioid combinations for review, and reduce the dose of the opioid or other sedating medicine(s) carefully as appropriate.
- Adhere to NI Formulary Guidance (including cautions) when managing pain.

Action for community pharmacies:

- Ensure patients prescribed high risk opioid combinations are advised of possible signs that may indicate central nervous system depression, such as sedation, lethargy or shortness of breath.
- Put procedures in place to help identify patients who may be at increased risk, considering both prescription and OTC medicines.
- Where appropriate, highlight potential issues to the prescriber to ensure that any necessary interventions are made.

Further resources can be found in the Pain Section of the Primary Care intranet.

Shortages Information

The UK Medicines Shortage Response Group (MSRG) meet on a weekly basis and review the situation with medicines supply on a national level; colleagues from Department of Health (NI) are involved in these discussions.
When a medicines supply issue is considered critical, national information is drafted by the MSRG and this will be cascaded to primary care via HSCB.

Manevac shortage

There is a current shortage of Manevac® granules.

Prescribers are asked to refer to the NI formulary when seeking an alternative product.

Cascade of information to GP practices:

- If the medicines supply issue relates to a drug prescribed by more than 50 GP practices, the information will be sent to all GP practices (via Regional GMS correspondence).
- If the medicines supply issue relates to a drug which is not commonly prescribed, the information will only be sent to GP practices who have prescribed the drug within the last 3 months (via local Integrated Care offices).
- All shortages information is available on the BSO website: http://www.hscbusiness.hscni.net/services/3065.htm and the monthly bulletin produced by DHSC in relation to medicines shortages is available on the Primary Care intranet: http://primarycare.hscni.net/pharmacy-and-medicines-management/dhsc-monthly-bulletin/.

Cascade of information to community pharmacies:

Information will be shared with community pharmacies (regardless of prescribing volume) via the BSO website: http://www.hscbusiness.hscni.net/services/3065.htm.

Rivastigmine patches: risk of errors

Rivastigmine transdermal patch is indicated for the symptomatic treatment of mild to moderately severe Alzheimer's dementia. The number of manufacturers and range of rivastigmine patches in the UK are increasing. Despite the MHRA Drug Safety Update (2010), medication errors continue to be reported. The most frequent errors are failure to remove the old patch and application of more than one patch at the same time, leading to rivastigmine overdose. Symptoms include sweating, nausea, vomiting, and diarrhoea and can lead to renal failure, bradycardia and hypotension, which is a medical emergency.

Actions:

- Counsel patients and caregivers on the correct use of rivastigmine patches.
- Encourage patients and caregivers to keep a record of when the patch was removed and when it was replaced, e.g. by using the manufacturer provided medication record diaries or writing the day of the week or date on the patch. For the latter, care should be taken not to damage or tear the backing liner.
- Pharmacy dispensing labels should clearly state the frequency of patch removal and renewal, e.g. "Apply ONE patch every TWENTY-FOUR hours. Remove and discard old patch before applying a new patch to a different location."
- In a case of suspected overdose, all rivastigmine patches should be removed immediately and no further patch applied for the next 24 hours.

Instructions for patients and caregivers:

- Apply each day to healthy skin on the upper or lower back, upper arm, or chest.
- Replace with a new patch after 24 hours.
- Remove the previous day's patch before application of a new patch to a different skin location.

MANAGED ENTRY DECISIONS

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

- Avatrombopag (Doptelet®)
- Ranibizumab (Lucentis®)
- Apalutamide (Erleada®)
- Daratumumab (Darzalex®)
- Teduglutide (Revestive®)
- Plerixafor (Mozobil®)
- Lenalidomide (Revlimid®)
- Cinacalcet hydrochloride **granules** 1mg, 2.5mg and 5mg (Mimpara® granules)
- Emtricitabine/tenofovir disoproxil (Truvada®)

NICE GUIDANCE NI SERVICE NOTIFICATIONS

Service Notifications have been issued in Northern Ireland for the following:

NICE TA599 – Sodium zirconium cyclosilicate for treating hyperkalaemia.

NOT recommended:

NICE TA621 – Osimertinib for untreated EGFR mutation-positive non-small-cell lung cancer.

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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