NORTHERN IRELAND MEDICINES MANAGEMENT

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Health and Social Care Board

NEWSLETTER

In This Issue

Muscle relaxants 'ineffective' for low back pain

Muscle relaxants (e.g. baclofen, tizanidine, methocarbamol, diazepam) are largely ineffective for low back pain, according to an analysis of the latest evidence. Researchers in Australia investigated the effectiveness, acceptability, and safety of muscle relaxants compared with placebo, usual care, or no treatment in adults with non-specific low back pain from data from 31 randomised control trials (RCTs). *[Ref — BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n1446 (Published 08 July 2021)]*

Summary of the review:

- Muscle relaxants might reduce pain in the short term, but the effect is too small to be clinically meaningful, and there is a risk of adverse effects.
- The certainty of evidence is low and large trials are needed to answer uncertainties around using these drugs in back pain.

NICE have recently published an update to their guideline NG59, *Low back pain and sciatica in over 16s: assessment and management*. Muscle relaxants are not recommended. Current prescribing outside of recommended guidance should be reviewed as part of shared decision making.

Despite this, £840,000 was spent last year in NI on non-benzodiazepine muscle relaxants (£450,000 on methocarbamol alone).

Methocarbamol is on the NI Limited evidence list and is listed in the BNF as 'less suitable for prescribing', as the evidence for its use in muscle spasm or spasticity is limited. Patient information leaflets have been developed and are available on the NI Formulary website to help people stop or reduce their methocarbamol.

ACTION:

- Prescribers are encouraged to follow NICE guidance on low back pain and sciatica.
- Prescribers are asked to review muscle relaxants for ongoing appropriateness, and reduce or stop where necessary.

Caution: drug formulation changes

It is important to be extra vigilant when changing the formulation of a drug to ensure the correct dose has been maintained. In a recently reported adverse incident, the formulation of metformin was changed from tablet to liquid, but the dose was incorrectly changed. In this incident, the dose of tablets was 500mg BD. However, when the liquid formulation was prescribed (500mg /5ml), the dose was incorrectly written as 10ml (1000mg) BD.

Learning for the prescriber:

- Work in a quiet area with minimal distractions.
- Either get a second check before printing the prescription, or leave the prescription and return with "fresh eyes" to do the final check.
- Reduce the time pressures on work to a minimum.

Learning for the Community Pharmacy:

- If the patient has been stable on a specific dose and the dose changes when the formulation does, check this is correct with the prescriber.

Deprescribing: bisphosphonates

Bisphosphonates are used in the management of osteoporosis and demonstrate efficacy in fracture risk reduction over 3 to 5 years of treatment. Their effect lasts for several years after treatment cessation. Long term treatment may increase bone fragility, by suppressing normal bone remodelling, essential for repair of skeletal micro-damage. The MHRA has issued a warning of the risk of atypical femoral fractures with long term bisphosphonate use: 'The need for continued treatment should be re-evaluated periodically based on the benefits and potential risks of bisphosphonate therapy for individual patients, particularly after 5 or more years of use'

ACTION: Prescribers should use the femoral T score when reviewing patients who have been receiving treatment for between 5 and 10 years and if the score is T score ≥ -2.5 then need should be assessed and either **deprescribing** or a **drug holiday** should occur.

Deprescribing

Deprescribing involves identifying the point at which a drug is no longer providing a worthwhile benefit and may actually be causing harm.
Deprescribing a bisphosphonate should be considered if:

- medication is taken for 3 to 5 years or more and there is a low fracture risk (femoral T score >-2.0)
- risks outweigh benefits
- patient develops swallowing difficulties
- poor adherence despite counselling
- limited life expectancy
- atypical femoral fracture occurs
- osteonecrosis of jaw or external auditory canal occurs
- treatment length > 10 years.

Nearly £2 million was spent last year in NI on bisphosphonates.

Figures for NI show for January to March 2021:

- 2,343 patients had been on treatment for >10 years
- 8,555 patients had been on treatment 5 to 10 years

The bisphosphonate may be stopped immediately. Patients should be given advice about lifestyle changes if appropriate (weight loss, exercise, stopping smoking and a healthy diet) which may help to reduce any risks associated with osteoporosis.

Drug Holiday

Depending on the patient risk factors (femoral T score >-2.5) a drug holiday may be appropriate. For risedronate and ibandronate, place the patient on a 1 to 2 year drug holiday; for alendronic acid place the patient on a 2 to 3 year drug holiday. If clinical circumstances change, an earlier review may be required.
Ensure the drug holiday is appropriately coded with a due diary date added to ensure patients are easily found and re-reviewed after the elapsed time. Once drug holiday period has elapsed, reassess patients fracture risk and restart treatment if appropriate. Where possible and appropriate, align choices to the NI Formulary recommendations.

NICE GUIDANCE — NI SERVICE NOTIFICATIONS

Service Notifications have been issued in NI for the following:
NICE TA711 — Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs
NICE TA712 — Enzalutamide for treating hormone-sensitive metastatic prostate cancer
NICE TA713 — Nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy (review of TA484)
NICE TA715 — Adalimumab, etanercept, infliximab and abatacept for treating moderate rheumatoid arthritis after conventional DMARDs have failed (part review of TA375)
NICE TA718 — Ixekizumab for treating axial spondyloarthritis
NICE TA719 — Secukinumab for treating non-radiographic axial spondyloarthritis.

MANAGED ENTRY DECISIONS

- 5-aminolevulinic acid medicated plaster (Alacare®)
- Delafloxacin (Quofenix®)
- Dupilumab (Dupixent®)
- Guselkumab (Tremfya®)
- Nivolumab (Opdivo®)
- Ozanimod (Zeposia®)
- Pembrolizumab (Keytruda®)
- Relebactam + cilastatin + imipenem (Recarbrio®)
- Tafamidis (Vyndaqel®)
- Upadacitinib (Rinvoq®)
- Vigabatrin 100mg and 500mg soluble tablets (Kigabeq®)

For full details see Managed Entry section of NI Formulary

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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