DoH Strategic Planning and Performance Group

NORTHERN IRELAND MEDICINES MANAGEMENT Newsletter

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Quinine—not for routine treatment of nocturnal leg cramps

Studies suggest quinine reduces leg cramps by about 1 episode/week. Manufacturers advise that the risks, which include significant adverse drug reactions (ADRs) and interactions, should be carefully considered relative to the potential benefits before using for leg cramps. The risks are particularly concerning in the elderly.

Image by Freepik

MHRA recommend:

- Quinine should not be considered routine treatment for nocturnal leg cramps.
- Only consider when cramps cause regular sleep disruption, **after weighing risks relative to potential benefits**, and when:
  - ◊ cramps are very painful/frequent
  - ◊ treatable causes are ruled out
  - ◊ non-pharmacological measures failed, e.g. passive-stretching exercises
- Cramp reduction may take 4 wks. Monitor closely during early stages for ADRs.

Although generally tolerated at doses for leg cramps, adverse effects may include:

- Unpredictable, life-threatening thrombocytopenia — warn patients to stop and consult prescriber if they develop unexplained petechiae, bruising, or bleeding
- Cinchonism (even at normal doses) - stop if they develop tinnitus/impaired hearing, headache, nausea, disturbed vision, confusion, flushing, abdominal pain.

Before prescribing, and on review, be aware of quinine's:

- **Significant interactions**: Monitor use with phenobarbital or carbamazepine: serum levels could increase, causing anticonvulsant toxicity
- **Dose-dependent QT-prolonging effects**: MHRA advises caution in patients predisposed to QT prolongation (e.g. pre-existing cardiac disease), taking other medicines which prolong QT interval or with atrioventricular block.

Action for GP practices:

Existing patients

- Review — offer a drug holiday — see resources on PCI
- If treatment continues, reassess every 3 months.

New patients

- Do not prescribe if previous adverse reaction (including from beverages).
- Assess risks versus benefit. If proceeding:
  - ◊ Warn patients not to overdose (irreversible blindness +/- death)
  - ◊ Stop after 4 weeks if no benefit.
  - ◊ If a benefit is seen, reassess every 3 mths.

New CEC: Peppermint oil 0.2ml gastro resistant capsules

Peppermint oil 0.2ml gastro-resistant modified release capsules / Colpermin® caps	→	Peppermint oil 0.2ml gastro-resistant capsules new

SPPG have recently added the above switch to the Cost-effective choices (CEC) list. This has the potential to generate over £80,000 of efficiency savings annually.

Action for GP practices:

- Identify all patients prescribed peppermint oil 0.2ml gastro-resistant modified release (MR) capsules (included branded preparations, e.g. Colpermin®)
- Consider switching to **peppermint oil 0.2ml gastro-resistant capsules.**
- New patients being initiated on peppermint oil capsules should be prescribed **peppermint oil 0.2ml gastro-resistant capsules**.
- Inform local community pharmacies of planned switches

Action for community pharmacies:

- Reduce stock of peppermint oil gastro-resistant MR capsules (including branded preparations) in anticipation of a switch.

In this issue

NICE Guidance

Recently published:

NICE TA915 NICE TA919
NICE TA920 NICE TA921
NICE TA927 NICE TA933
NICE TA918 NICE TA944
NICE TA755 NICE TA935
NICE TA943 NICE TA946

Managed Entry Decisions

Full details here

- Trastuzumab deruxtecan (Enhertu®)
- Osilodrostat (Isturisa®)
- Foslevodopa + foscarbidopa (Produodopa®)
- Atogepant (Aquipta®)
- Velmanase alfa (Lamzede®)
- Sebelipase alfa (Kanuma®)
- Mercaptamine bitartrate (Procysbi®)
- Pembrolizumab (Keytruda®)
- Velmanase alfa (Lamzede®)
- Ivosidenib (Tibsovo®)
- Loncastuximab tesirine (Zynlonta®)
- Olaparib (Lynparza®)
- Degarelix (Firmagon®)
- Efgartigimod
- Risdiplam (Evrysdi®)

Deprescribing social media campaigns

This month the focus of deprescribing is gabapentinoids, lidocaine patches, and rubefacients. A patient-facing social media campaign will accompany this work. Details can be found on the Health and Social Care NI Facebook page or our website. Please share further on your social media platforms. Refer also to Deprescribing section on the NI Formulary website for resources to support deprescribing.

Deprescribe: Gabapentinoids for non-malignant, non-palliative chronic pain

Pregabalin and gabapentin (gabapentinoids) are **high risk medicines**. They can cause serious side-effects including respiratory depression, cognitive impairment, sedation, dependence and addiction. Risks are significantly increased when gabapentinoids are co-prescribed with opioids, and other sedatives including alcohol. In 2021, gabapentinoids were recorded on **83 NI death certificates** (pregabalin 71 and gabapentin 12) - an increase from only 2 in 2013. Gabapentinoids are Schedule 3 **controlled drugs** covered by legislation, to ensure safe and appropriate use.

Resources
Implementation Support Tool for Non-Malignant Neuropathic Pain in Non-Specialist Settings - New Patients

There has been a move away from using medication for chronic pain due to limited benefit. If medication is considered necessary, this should be in line with NICE, where gabapentinoids have a **limited role**, i.e. for neuropathic pain (except trigeminal neuralgia). Gabapentinoids should not be offered for other types of chronic pain, e.g. fibromyalgia, low back pain or, sciatica. Note: pregabalin is **not** a NI Formulary option.

However, in Northern Ireland, 564,000 prescriptions for pregabalin and gabapentin were issued last year.

Actions:

- Review gabapentinoid prescribing for chronic pain and aim to reduce/stop (slowly) as appropriate (exclude prescribing for cancer/palliative care).
- Prioritise those at higher risk, e.g. co-prescribed strong opioids (i.e. morphine, oxycodone, fentanyl, tapentadol, buprenorphine, tramadol), elderly, pregnant or with respiratory disease.
- Take account of shared decision making and best practice relating to medicines associated with dependence or withdrawal
- Educate patients on potential risks, and alternative chronic pain non-pharmacological/self-management strategies. Signpost accordingly, e.g. Better Days, Versus Arthritis, My live well with Pain, The Pain Toolkit.
- Consider less harmful alternatives before prescribing gabapentinoids.
- Monitor regularly and document clearly.

Display / share this poster / leaflet.

Deprescribe: lidocaine plasters

Lidocaine plasters are licensed for symptomatic relief of neuropathic pain associated with post-herpetic neuralgia in adults; all other use is off-license. NICE do not include lidocaine plasters in their guidance on neuropathic pain as only very limited evidence on this treatment met their inclusion criteria; evidence in other types of pain is also limited. **Lidocaine plasters have therefore been added to the Limited Evidence list and are NOT included in the NI Formulary. However, in Northern Ireland, over £2 million was spent on lidocaine plasters last year.**

Actions:

- Do not initiate lidocaine plasters for rib fracture or back pain in primary care.
- All new patients must be reviewed within 2 to 4 weeks to check for benefit. If there is no response after 2 to 4 weeks, treatment must be stopped as potential risks may outweigh benefits. No step down is needed.
- Treatment should be reassessed at regular intervals to decide if the plasters continue to benefit the patient, whether the amount of plasters needed to cover the painful area can be reduced, or if the plaster-free period can be extended.
- Review patients prescribed lidocaine plasters. If there is no benefit (i.e. reduced pain, improved sleep / wellbeing / function), discontinue use. Where the person needs continued treatment, consider alternative treatments appropriate to the indication. Refer to SOP for review of prescribing for non-palliative patients.

Resources
- Patient Information Leaflet
- PrescQIPP Lidocaine plasters (DROP-List)

Deprescribe: rubefacients

Rubefacients, e.g. Movelat® gel/cream, are used for the treatment of soft-tissue disorders and pain relief. There is limited evidence that rubefacients work. The BNF states that evidence does not support the use of rubefacients in short- or long-term muscle pain. Current annual expenditure on rubefacients is approximately £30,000. In addition, NICE CG177 states that rubefacients should not be offered to treat osteoarthritis. **Rubefacients have therefore been added to the Stop List and are NOT included in the NI Formulary.**

Actions:

- Search for patients on GP clinical system currently prescribed Movelat® gel or cream (generic; mucopolysaccharide polysulphate/salicylic acid).
- Any patients identified should have their therapy reviewed and discontinued. If patients still wish to use a rubefacient, they should be advised to purchase.
- If considered appropriate, a topical NSAID gel may be considered for patients with knee or hand osteoarthritis (the 1st line NI Formulary choice of NSAID gel is Ibuprofen 5% gel).
- No new patients should be initiated on rubefacients.

Image by Freepik