DoH Strategic Planning and Performance Group

NORTHERN IRELAND MEDICINES MANAGEMENT
Newsletter
Volume 15 Issue 6 June 2024

Coroner alert: Death caused by Oxycodone and Pregabalin Toxicity

An Assistant Coroner has released a 'Prevention of Future Deaths Report', relating to a death caused by oxycodone toxicity enhanced by pregabalin, both prescribed for fibromyalgia and chronic pain. The agoraphobic patient who had been on this combination over a long period, had ongoing mental health illness and what appeared to be iatrogenic drug dependency. There was no evidence of any attempt to review the prescriptions of two dependency forming drugs with a view to reducing the dose over time. The Coroner noted a risk that future deaths could occur unless action is taken.

Key Learning

1. There has been a move away from using medication to treat chronic pain due to limited benefit. Medication, if considered necessary, should be in line with NICE Guidance. **The following should not be offered for chronic non-malignant pain**:
   a) Strong opioids (e.g. oxycodone, morphine, fentanyl, buprenorphine, tramadol) - minor exceptions only.
   b) Gabapentinoids with the exception of neuropathic pain. **Note:** pregabalin is not a NI Formulary option.
2. Opioids and gabapentinoids can cause serious side-effects (e.g. respiratory depression) as monotherapy. Risks are significantly increased at higher doses and if co-prescribed.
3. Oxycodone and pregabalin are controlled drugs (CDs). Prescribers are legally responsible for clinical monitoring of all CDs. Practice CD SOPs should outline procedures for this (See Section 7 of SPPG CD Guidance). All opioids should be reviewed at least six monthly (Opioids Aware).

Action for GP Practice Staff:

- Urgently prioritise for review patients on opioid and gabapentinoid combination for chronic non-malignant pain (excluding palliative care). Further prioritise strong opioids and higher doses/oral morphine equivalence (See NI Guidance for Converting Opioid Doses). Action should be taken following a review.
- Aim to step down slowly in line with best practice relating to medicines associated with dependence or withdrawal and shared decision making
- Check that robust systems/SOPs for regular clinical monitoring of all CDs (Schedule 2 to 5) are in place in your practice, and are being adhered to.
- Implement a practice policy for the safe initiation and review of opioids and gabapentinoids (See Opioid Resource Pack*)

*SPPG is in the process of progressing a similar Gabapentinoid Resource Pack

Clozapine & Potential Serious GI Side Effects

Clozapine is a second-generation antipsychotic, predominantly used for treatment-resistant schizophrenia. Measures should be in place to ensure that clozapine, a red list drug, is NOT prescribed or dispensed in primary care. In a previous newsletter article, SPPG reminded practitioners that clozapine is associated with a number of serious clinical risks, including constipation and paralytic ileus, of which all healthcare professionals should be aware.

Image by brgfx on Freepik

As a further reminder: Clozapine has been associated with varying degrees of gastrointestinal (GI) impairment or gastric hypomotility. As highlighted by the MHRA in 2017, constipation is a very common side effect of clozapine but can rarely be associated with intestinal obstruction, faecal impaction and paralytic ileus. On a few occasions, cases have been fatal.

Continued over page

In this issue

NICE Guidance

Recently published:

NICE TA967— Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma in people 3 years and over (partial review of TA540)

NICE TA970 — Selinexor with dexamethasone for treating relapsed or refractory multiple myeloma after 4 or more treatments (review of TA700)

NICE TA971 — Remdesivir and tixagevimab plus cilgavimab for treating COVID -19

NICE TA973 — Atogepant for preventing migraine

NICE TA974 — Selinexor with bortezomib and dexamethasone for previously treated multiple myeloma (review of TA700)

NICE TA975 — Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 25 years and under (review of TA554)

NICE TA977— Dabrafenib with trametinib for treating BRAF V600E mutation-positive glioma in children and young people aged 1 year and over

Managed Entry Decisions

No Managed Entry decisions were made this month. Previous decisions can be found here

Reminder of warnings in the product information

- Clozapine is contraindicated in patients with paralytic ileus
- When prescribing clozapine, particular care should be taken in patients at risk of constipation, including those:
  - ◊ Receiving medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments)
  - ◊ With a history of colonic disease or a history of lower abdominal surgery
  - ◊ Aged 60 years and older

Actions for GP practices and community pharmacies:

Advise patients:

- That if they develop constipation, they should tell their doctor immediately before taking the next dose of clozapine.
- It is vital that constipation is recognised early and actively treated.

Refer to the full summary product of characteristics for a complete list of warnings and recommendations for clozapine.

Resources

For more information on managing constipation in patients taking clozapine, check out the following resources:

- Specialist Pharmacy Service
- Choice and medication Handy factsheet

Learning module

Community Pharmacists can access an e-learning Clozapine module (10 hours CPD) via NICPLD: Clozapine Module Dashboard (nicpld.org)

image: Freepik.com

Deprescribe: antibiotics for UTI prevention

For non pregnant women with recurrent urinary tract infections (UTI), NICE guidance NG112 recommends we consider a trial of antibiotic prophylaxis **ONLY** if behavioural and personal hygiene measures and vaginal oestrogen (in postmenopausal women) are not effective or not appropriate. Patients should be advised antibiotic prophylaxis is not usually a life-long treatment.

NICE recommends reassessing the need for antibiotic prophylaxis at least every 6 months. There is no evidence of additional benefit beyond 6 to 12 months. The clinical decision to continue prescribing should be documented in the patient's notes and the patient informed of the risks of continued long-term antibiotic therapy see below.

Risks associated with antibiotic prophylaxis:

- Diarrhoea occurs in 2 to 25% of people (CKS)
- Increased likelihood of infection with a resistant organism
- Risk of developing a healthcare associated infection such as *C.difficile*
- Nitrofurantoin has a risk of pulmonary and hepatic adverse drug reactions MHRA DSU
- Quinolones must only be prescribed when other commonly recommended antibiotics are inappropriate due to the risk of potentially long-term or irreversible side effects MHRA DSU
- Trimethoprim has a teratogenic risk in the first trimester of pregnancy.

Action for practices:

Review antibiotic prophylaxis for recurrent UTI at least every 6 months to include:

- Reminders about behavioural, hygiene measures, and self-care treatments (per NICE recommendations)
- Assessing the success of prophylaxis and ensuring rapid treatment access if an acute UTI occurs
- Discussing the continuation, cessation, or change of prophylaxis based on patient preferences and antimicrobial resistance risk
- Providing information on UTI prevention and dehydration management.

Resources

- TARGET webinars and audits Urinary tract infection resource suite
- TARGET TYI-UTI patient information leaflet
- Tackling dehydration
- The I-Hydrate Project (uwl.ac.uk)