NORTHERN IRELAND MEDICINES MANAGEMENT

October 2013 Volume 4, Issue 5

Health and Social Care Board

NEWSLETTER

MATERIALS AND E-RESOURCES SUPPORT THE NEW ANTIMICROBIAL GUIDELINES

The new **Northern Ireland Management of Infection Guidelines for Primary Care 2013** have now been distributed to all GP practices, community pharmacies, urgent care centres and emergency departments in Northern Ireland. Developed by an expert review group, they promote the safe, effective and economic use of antibiotics. Prescribers are encouraged to adhere to the recommendations in these guidelines to help minimise the emergence of bacterial resistance in the community.

Paper resources to support the guidelines include:

- An A4 laminated summary of the 2013 guidelines for use by prescribers.
- An A3 poster for display in patient areas.
- Two patient information leaflets which explain viral conditions and provide general advice on treating self-limiting infections in both adults and children.

On-line resources are also available:

- Condition-specific patient information leaflets. These are one-sided A4 in black and white for ease of printing and encourage patients to self-manage conditions such as common cold & flu-like illness, sore throat, acute bronchitis, sinusitis and otitis media.
- An audit tool is available on the primary care intranet to assist prescribers in the implementation of these guidelines.

The guidelines and all the supporting resources are available on the HSCB website and can be accessed via the HSCB intranet (Pharm and Meds Management Tab > Resources > Clinical Resources > Antimicrobials) or by using the shortcut www.tinyurl.com/antibioticsNI

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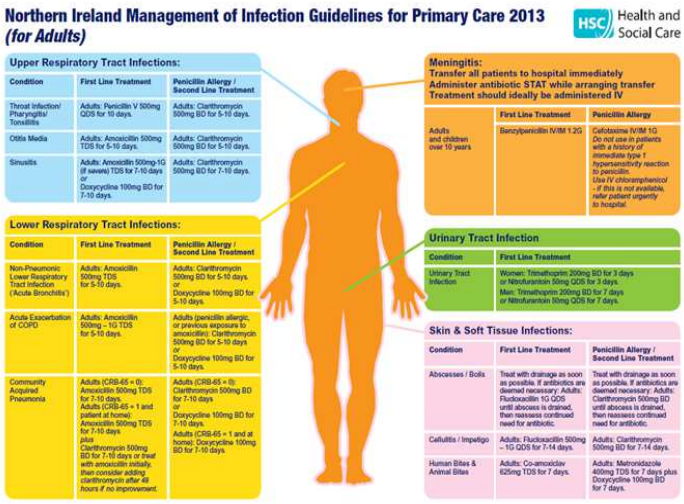


Additional links

Antibiotic prescribing resources:
http://www.publichealth.hscni.net/publications/antibiotic-prescribing-resources-health-professionals

Information sheet on managing a sore throat: http://www.publichealth.hscni.net/publications/antibiotics-information-general-public.

Action:

- Never accept telephone requests without speaking to the patient and discourage these requests.
- Insist on seeing all under 5's in the surgery.
- Prescribe an antibiotic ONLY when there is a clear clinical benefit.
- Consider alternatives for the patient including the new patient self-management information sheets
- If a prescription is required, adhere to the guidelines. Avoid co-amoxiclav, quinolones and cephalosporins.
- Put up the posters, bookmark the on-line resources and use the audit tool.

STOPPING RULES WITH NEWER ANTI-DIABETIC DRUGS [9]

In the management of type 2 diabetes, NICE recommends that metformin should be used as first-line treatment, with a sulfonylurea as second-line treatment (unless contraindicated) and isophane insulin as the preferred third-line drug.

Several new classes of anti-diabetic drugs have entered the market in recent years. Currently, long term evidence on impact of the newer drugs on endpoints such as diabetic complications, morbidity and mortality is lacking. Furthermore, adverse effects may only become apparent over time when these agents have more widespread use in a diverse population.

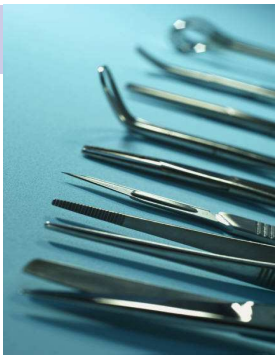
It is therefore crucial not to expose people with type 2 diabetes to the risks of these drugs in the face of inadequate metabolic benefit. NICE has provided stopping rules for a number of new anti-diabetic drug classes. The Medicines Management Team advises that these stopping rules should be applied to all drugs within the same class unless directed otherwise by NICE. Therefore therapy with glitazones (pioglitazone), gliptins (linagliptin, saxagliptin, sitagliptin and vildagliptin), GLP-1 agonists (exenatide, liraglutide, lixisenatide) should only be continued if the patient has a beneficial metabolic response after 6 months of treatment. The definition of 'beneficial metabolic response' depends on the drug class and regimen used (dual or triple therapy) and is shown in the table above.

Drug class	Reduction in HbA1c required at 6 months	Weight loss required at 6 months
Glitazone	≥ 6mmoL/mL (0.5%)	-
Gliptin	≥ 6mmoL/mL (0.5%)	-
GLP-1 agonist (*dual* therapy)	≥ 11mmoL/mL (1.0%)	-
GLP-1 agonist (*triple* therapy)	≥ 11mmoL/mL (1.0%)	≥ 3% body weight

According to NICE costing templates for GLP-1 agonists, 2.8% of type 2 diabetic patients will meet the NICE criteria for a GLP-1 agonist. This corresponds to a predicted spend of approximately £58,000 per year in Northern Ireland for liraglutide. However, actual spend on liraglutide last year in Northern Ireland was close to £2.3 million.

Action:
Glitazones, gliptins and GLP-1 agonists should be stopped after 6 months if a beneficial metabolic response is not achieved.

SSRIs AND RISKS IN SURGERY [4]



A recent article in JAMA Internal Medicine highlighted the potential for an increased risk of adverse outcomes of surgery (such as bleeding and mortality) when SSRIs are used in the perioperative period. Reports seem to the limited to single-site studies. Multicentre studies (that include a range of surgical procedures and that specify the indications of SSRIs) are needed to determine whether patient factors or SSRIs themselves are responsible for elevated risks.

Action:
GPs should ensure SSRIs are highlighted on referral letters or to pre-op clinics.

Drug Safety Update — MHRA

REMINDER: NITROFURANTOIN — CAUTION IN RENAL IMPAIRMENT

The MHRA issued a reminder to healthcare professionals in a recent Drug Safety Update on the caution with nitrofurantoin in renal impairment.

Nitrofurantoin is often used in the treatment of urinary tract infections. The antibacterial efficacy in this infection depends on the renal secretion of nitrofurantoin into the urinary tract. In patients with renal impairment, renal secretion of nitrofurantoin is reduced, which can result in treatment failure. Nitrofurantoin is therefore contraindicated in those with a glomerular filtration rate (GFR) <60 mL/min.

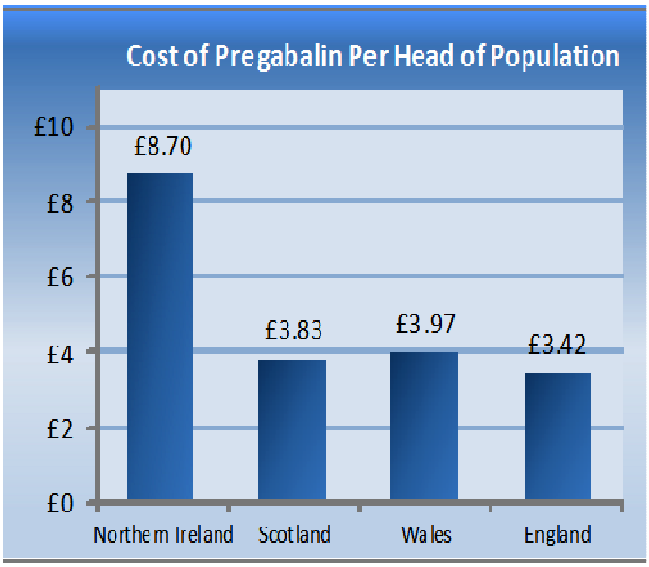
Since January 2012, the MHRA have received 11 reports of patients with renal impairment who had experienced an inappropriate prescription of nitrofurantoin, some of which resulted in treatment failure.

Action:

- Be aware of current renal function when prescribing nitrofurantoin, especially for elderly patients.
- Nitrofurantoin is contraindicated in those with GFR<60 mL/min.
- The product information should be consulted in relation to established risks of nitrofurantoin, which include: pulmonary toxicity; hepatic toxicity; peripheral neuropathy; and contraindications in G6PD deficiency and acute porphyria.
- Guidance on the appropriate use of antibiotics and the prevalence of resistance (such as NICE guidance) should be considered when prescribing nitrofurantoin.

PREGABALIN ABUSE IN NORTHERN IRELAND

Cost of pregabalin per head of population was considerably higher last year in Northern Ireland than in other parts of the UK, as depicted in the graph.



Reports from the HSCB Substitute Prescribing Group and the DHSSPS Prescription Drug Misuse group have highlighted the issue of pregabalin misuse/abuse, and they have written to the Advisory Council on Misuse of Drugs in London about their concerns.

In addition, recent work on Prescribing Safety Indicators has highlighted a number of patients who are exceeding the maximum dose of pregabalin (600mg) or are 'over-ordering' prescriptions.
There are a number of actions practices can undertake to minimise the risk of misuse/abuse of pregabalin.

Action:

- Practices should treat pregabalin as a drug liable to abuse and put robust repeat prescribing protocols in place.
- Quantities should be kept to a maximum of 28 days where possible.
- Practices should be vigilant for patients over-ordering and/or reordering repeat prescriptions too early.
- Doses should be 'Twice Daily' and 'doubling up' should be avoided i.e. prescribe 1x100mg rather than 2x50mg (so that volumes are minimised).
- HSCB have a number of resources to support practices such as the Repeat Prescribing Audit and Pregabalin Review Tool.

Drug Safety Update — MHRA

METOCLOPRAMIDE — NEW RESTRICTED DOSE AND DURATION OF USE [5,8]

The European Medicines Agency (EMA) recently conducted a review into the risks and benefits of metoclopramide. The review confirmed the well known risks of neurological effects such as short-term extrapyramidal disorders and tardive dyskinesia. The review has led to changes in the prescribing advice for metoclopramide, including a restriction to the dose and duration of use, and in the paediatric population.

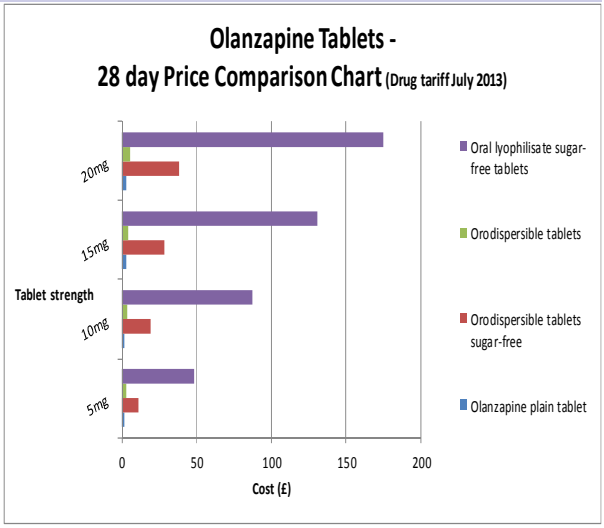
Since the EMA recommendation, one of the marketing authorisation holders for metoclopramide requested a re-examination of the evidence. The EMA will now re-examine its recommendation and issue a final opinion.

Action:

- Use of metoclopramide is now contraindicated in children younger than 1 year.
- Metoclopramide should only be prescribed for short-term use (up to 5 days) for both adults and children.
- The maximum dose of the medicine has been lowered in adults to a total of 30 mg a day.
- Children should now only be prescribed metoclopramide for the prevention of nausea and vomiting that occurs in the days after treatment with anticancer medicines, or to treat nausea and vomiting after surgery, and only when other treatments do not work or cannot be used.
- Adults should now only be prescribed metoclopramide for prevention of postoperative nausea and vomiting; radiotherapy-induced nausea and vomiting; delayed (but not acute) chemotherapy-induced nausea and vomiting; and symptomatic treatment of nausea and vomiting, including that associated with acute migraine (where it may also be used to improve absorption of oral analgesics).
- Metoclopramide should no longer be used to treat conditions such as indigestion, heartburn and acid reflux, or chronic (long-term) disorders due to slow emptying of the stomach.
- Patients taking metoclopramide for long-term conditions should have their treatment reviewed at the next scheduled appointment.
- Refer to the SPCs for full details on the new prescribing advice.

COST-EFFECTIVE PRESCRIBING OF OLANZAPINE

Three generic versions of olanzapine orodispersible tablets are available (see chart). In order to achieve any associated savings, the correct generic description must be used when prescribing these products. Generic "olanzapine orodispersible tablet" is the most cost-effective of the three and should be written as such whenever an orodispersible tablet is prescribed. By changing the generic description of orodispersible tablets to "olanzapine orodispersible tablet" this could result in **potential savings of over £270,000 per annum in Northern Ireland.**



Orodispersible tablets are however significantly more expensive than plain tablets and should only be prescribed when absolutely necessary. **If plain tablets were prescribed in place of orodispersible tablets, there is the potential to save over £500,000 per annum in Northern Ireland.**

Action:

First choice of olanzapine preparation should be olanzapine plain tablets. If a patient does require an orodispersible version, then the most cost-effective choice is "olanzapine orodispersible tablets".

ALLERGIES TO DRESSINGS [1,2,3]

Antimicrobial dressings are useful in managing infection at the wound site. However, they are not suitable in all patients due to problems with hypersensitivities. Problems with hypersensitivities include:

Honey Dressings

Patients should be carefully monitored for any allergic or irritant reactions. Honey dressings should not be used on patients with extreme sensitivity to honey, bee stings or bee products.

Silver Dressings

Silver dressings are contraindicated in patients with known sensitivities to alginates, silver or sulphonamides.

Alginate Dressings

Alginate dressings should not be used if there is a known allergy to alginate dressings.

Iodine Dressings

People with shellfish allergy are sometimes told to avoid iodine, an element present in items including shellfish, and seaweed. It is possible to be allergic to iodine, but in fact, iodine allergy is unrelated to shellfish allergy. The allergen present in shellfish is not iodine but muscle protein in the flesh of the shellfish.

Chlorhexidine Dressings

Be aware of the potential for an anaphylactic reaction to chlorhexidine.

Action:

- Ensure that known allergies are recorded in patient notes.
- Always check the labels and instructions for use prior to use on patients with a known allergy. The manufacturer's recommendations regarding contraindications to each dressing should be adhered to.
- Report allergic reactions to the MHRA. Further guidance on anaphylaxis is available from NICE, the Resuscitation Council and the Association of Anaesthetics of Great Britain and Ireland (AAGBI).

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 Medicines Management pharmacists in your local HSCB office.

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Every effort has been made to ensure that the information included in this newsletter is correct at the time of publication. This newsletter is not to be used for commercial purposes.

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