NORTHERN IRELAND MEDICINES MANAGEMENT NEWSLETTER

Volume 4, Issue 3

June 2013

Health and Social Care Board

In this issue:

PRODUCT FOCUS — OXYCODONE MR (LONGTEC®)[7]

There are several branded generic preparations of oxycodone modified release (MR) now available. Longtec® has been awarded the secondary care contract in Northern Ireland. This means that hospitals across Northern Ireland will be actively switching to the Longtec® brand of oxycodone MR. Patients will receive Longtec® as their brand of oxycodone MR both during their hospital stay and at discharge.

Action

HSCB policy is for modified release controlled drugs to be prescribed by brand name. It is therefore recommended that, where appropriate, practices prescribe oxycodone MR as the Longtec® brand to avoid confusion and to ensure consistency of supply across primary and secondary care.

Please see communication from HSCB for further details (HSCB letter, June 2013). Should you have any queries please contact your Medicines Management Adviser.

EMERGENCY CARE SUMMARY – IMPROVING THE QUALITY

The Emergency Care Summary (ECS) is used routinely in out-of-hours (OOHs), emergency departments and during hospital admissions to obtain a patient's current medication and allergy history. The ECS information will be included in the new Electronic Care Record (ECR) which is currently being rolled out across Northern Ireland. It is important that the ECS provides accurate medication and allergy information. The ECS includes medicines issued by the GP clinical system during the last 6 months.

Adding medicines issued outside the GP practice

It is important that the medication list is as accurate as possible and includes important medication such as Red List drugs where possible. To ensure that the medication information available in the ECS is as comprehensive as possible, it would be helpful if clinically important medication issued outside the practice could be added to a patient's record as follows:

- Merlok, Emis LV and Emis PCS: add the drug as 'issued but not printed'
- INPS: enter drug source as issued outside the practice or secondary care

Examples of medicines issued to patients outside the practice include:

- Medicines supplied from hospital
- Medicines prescribed during a home visit or by another service, e.g. OOHs

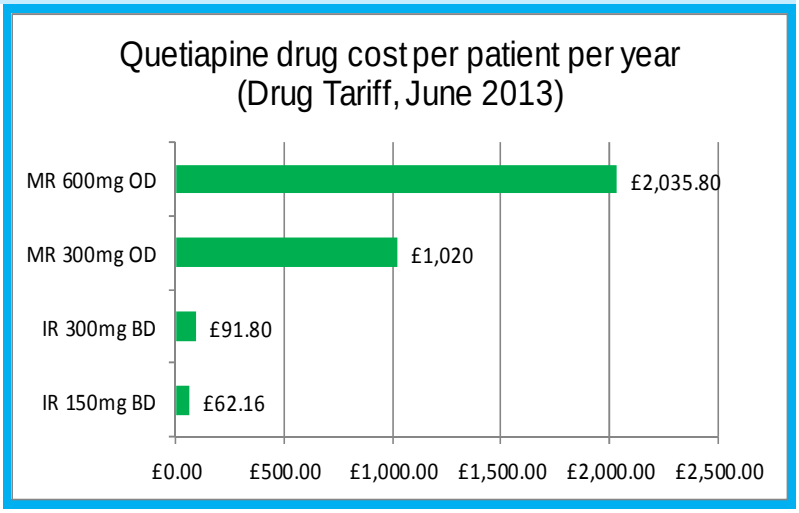
Good practice points to reduce potential for error associated with medication histories

- Acute medicines should be reviewed regularly and added to the patient's 'repeat' record where appropriate
- Medication/dose changes in response to hospital letters should be actioned immediately
- There should be less of a need for medication histories to be phoned/faxed to hospital admissions wards
- OOHs staff should always confirm ECS medication/allergy information with the patient or carer

The full guidance on entering allergy and medication information is available at:
http://primarycare.hscni.net/2543.htm

RATIONAL QUETIAPINE MR PRESCRIBING [4,8,10,11]

There is a significant cost difference between the immediate release (IR) and modified release (MR) formulations of quetiapine (as shown in this graph).



Once-daily dosing with quetiapine MR tablets is equivalent to twice-daily dosing with quetiapine IR tablets. Research findings indicate that modifying the formulation has no difference in efficacy. Studies comparing quetiapine MR and quetiapine IR have demonstrated little difference in terms of side effects.

The MR formulation may be considered in situations where the IR formulation is unsuitable. There may occasionally be patients who do not tolerate quetiapine IR, but do tolerate quetiapine MR, which could justify the use of quetiapine MR (see below). There is no evidence that a once-daily preparation is better than a twice-daily preparation from a compliance point of view. However once-daily dosing may improve compliance in some patients. Once-daily dosing offers convenience in patients who require supervision of medication.

Reasons to consider the MR preparation

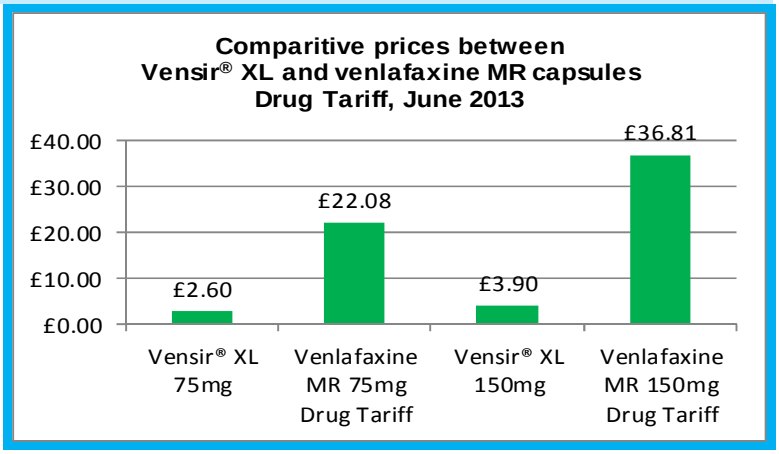
- Patient is at high risk of adverse effects to quetiapine (e.g. orthostatic hypotension).
- Patient experiencing adverse effects that are related to peak concentrations on twice a day quetiapine (e.g. sedation and somnolence).
- Patient has a clinical condition requiring a faster and less complicated titration to target dose.
- It is thought that once-daily dosing will improve compliance.

Action

- The majority of patients who require quetiapine should be managed on the IR formulation.
- Generally there is little need to use the MR preparations at “low doses” for short-term usage.
- Patients should not be started on MR quetiapine without first trying the IR formulation.
- Secondary care clinicians are asked to state clearly the reason for MR prescribing in the information to primary care.

PRODUCT FOCUS — VENLAFAXINE MR (VENSIR®) [8,13]

Vensir XL® remains the preferred Venlafaxine MR product for Northern Ireland. All hospitals stock this brand and the contract has recently been extended until December 2015. This brand remains the most cost-effective option, where this drug is indicated. Prescribing using this brand also ensures continuity between primary and secondary care.



Whilst savings are not apparent on GP clinical systems, this brand has the potential to release significant savings to your practice’s prescribing budget.

Information on this and other cost-effective branded products can be found at the link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/039%20HSCB%20Branded%20Generic%20Guidance%20-%20April%202013%20-PDF%2043KB.pdf
Should you have any queries please contact your Medicines Management Adviser.

APPROPRIATE DISULFIRAM (ANTABUSE®) PRESCRIBING [4-6]

Disulfiram is licensed as an adjuvant in the treatment of patients with drinking problems.
It is not included in the Red/Amber list, however it **should only be initiated in a hospital or a specialised clinic by physicians experienced in its use**.
Disulfiram is not considered first line therapy: NICE recommend that disulfiram may be considered for people with moderate and severe alcohol dependence who are not suitable for acamprosate (Campral EC®) or naltrexone, or who prefer and understand the relative risks of taking disulfiram.
For disulfiram to be effective, research shows that consumption must be supervised by a trusted relative, friend or the Addiction Service or local pharmacy.

Before starting treatment

- Baseline tests to be conducted by secondary care: BP, pulse, U+Es, LFTs, FBC and ECG (if indicated by possibility of cardiac disease).
- There are a number of significant contraindications to consider: cardiac failure, coronary artery disease, previous history of CVA, hypertension, severe personality disorder, suicidal risk or psychosis, consumption of alcohol and hypersensitivity to disulfiram.
- Treatment is started at least 24 hours after the last alcoholic drink consumed.
- Patients and their families and carers should be warned about the interaction between disulfiram and alcohol.

Disulfiram + Alcohol Interaction—"Disulfiram Reaction"

- Disulfiram gives rise to an extremely unpleasant systemic reaction after the ingestion of even a small amount of alcohol, because it causes accumulation of acetaldehyde in the body.
- Symptoms can occur within 10 minutes of ingesting alcohol.
- Symptoms include: flushing of the face, throbbing headache, palpitation, tachycardia, nausea, vomiting, and, with large doses of alcohol, arrhythmias, hypotension, and collapse; these reactions can last several hours. This reaction can result in death.
- Patients must be advised to avoid alcohol, including low alcohol or non-alcohol beers and wines. Some food, toiletries, perfumes, aerosol sprays and alcohol hand gels may contain enough alcohol to elicit a reaction.
- Patients should be advised that, if they consume alcohol, they will require referral to A&E.

During treatment

- It is vital that patients should be monitored at least every 2 weeks for the first 2 months, then monthly for the following 4 months, and at least every 6 months thereafter.
- Disulfiram is only effective if taken as prescribed—compliance is therefore very important.

Action

- Disulfiram should not be initiated in primary care; ensure patient is receiving specialist input for their drinking problem and that there is a treatment plan for each patient.
- Ensure no drug interactions with concomitant medicines.
- Ensure all blood tests are up-to-date.
- Monitor adherence (prescription collection).

DISCONTINUATION OF PRIPSEN SACHETS® [3,9]

Pripsen® sachets (piperazine; Thornton and Ross) have been discontinued. They are to be replaced by a tablet formulation of piperazine, but this will not be available for 18 months. Mebendazole is an alternative treatment for threadworms. It is licensed for children 2 years of age and above (this information is reflected in the patient information leaflet). However the Children's BNF advises that the drug of choice for treating threadworm infection in *children over 6 months* is mebendazole.

AGE-RELATED MACULAR DEGENERATION SUPPLEMENTS — UPDATE [1,2]

AREDS 2 Study
The latest study on supplements for age-related macular (AMD) degeneration, the AREDS 2 study, sought to determine whether the addition of lutein and zeaxanthin and/or docosahexaenoic acid and eicosapentaenoic acid to the original AREDS formulation offered additional benefit to the original formulation. Results showed that this addition did not further reduce the risk of progression to advanced AMD.

Clarification of original AREDS Study information
The original AREDS supplement formulation includes: vitamin C 500 mg, vitamin E 400 IU, vitamin A 15 mg (25,000 IU), zinc 80 mg, and copper 2 mg daily.

The original AREDS study reported that supplements given over a 5 year period may offer some benefit in reducing the relative risk of progression to late AMD in patients with advanced AMD (or vision loss due to AMD) in one eye and in people with intermediate AMD who have extensive intermediate-size drusen, at least one large druse, or non-central geographic atrophy in one or both eyes, compared to people who have never taken a supplement. However the benefit is small: the absolute risk reduction in slowing the progression of AMD was 28% down to 22% at 5 years. This correlates to a Number Needed to Treat (NNT) of 17.

Action
The message remains the same—there is insufficient evidence to recommend that supplements for AMD are prescribed on the NHS.

References

1. Chew EY et al. Lutein + Zeaxanthin and Omega-3 Fatty Acids for Age-Related Macular Degeneration: The Age-Related Eye Disease Study 2 (AREDS2) Randomized Clinical Trial. JAMA, 2013;1-11. doi:10.1001/jama.2013.4997.
2. CKS. Macular degeneration - age-related. Clinical Knowledge Summaries.
3. RPSGB/BMA. BNF for Children. Accessed 16/5/2013, [https://www.bnf.org].
4. RPSGB/BMA. BNF. Accessed 16/5/2013, [https://www.bnf.org].
5. EMC. Antabuse Summary of Product Characteristics last updated on the eMC: 11/01/2012, [http://www.medicines.org.uk].
6. NICE. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence CG115, 2011. [https://www.nice.org.uk].
7. HSCB communication to General Practitioners & Community Pharmacies. Longtec® (oxycodone MR tablets) – Implementation in Trusts, June 2013.
8. Drug Tariff June 2013. http://www.hscbusiness.hscni.net/services/2034.htm
9. Thornton and Ross, Personal communication , May 2013
10. EMC. Seroquel XL Summary of Product Characteristics last updated on the eMC: 27/11/2012, [http://www.medicines.org.uk].
11. EMC/ Seroquel. Summary of Product Characteristics last updated on the eMC: 26/11/2012, [http://www.medicines.org.uk].
12. Pharmacy Benefits Management Services. Criteria for Use of High Dose Vitamin Supplementation for Macular Degeneration. Accessed 18/6/2013 [http://www.pbm.va.gov/clinicalguidance/criteriaforuse/VitaminSupplementsforMacularDegenerationCriteriaForUse.pdf].
13. Morningside Healthcare. Vensir® promotional leaflet, 2013.

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.

Eastern Area Office: 028 9055 3784 Southern Area Office: 028 3741 4622

Northern Area Office: 028 2531 1049 Western Area Office: 028 7186 0086