Prescribing Points

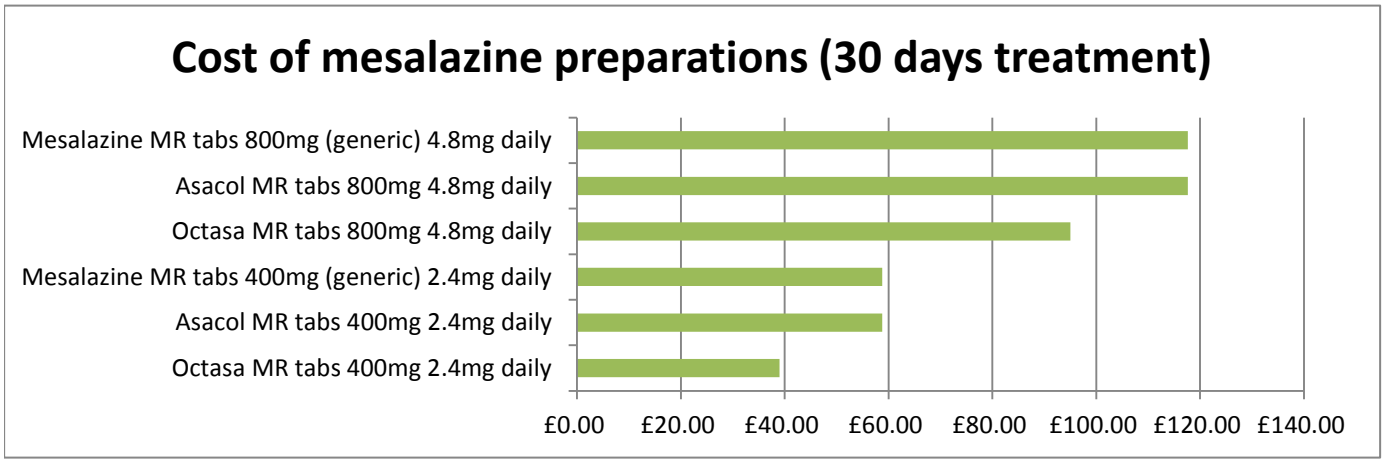
Volume 23 Issue 9 October 2014

Oxfordshire
Cinical Commissioning Group

Please let us know if you are receiving this newsletter and it is no longer relevant to you.
This newsletter is uploaded to the OCCG website . For queries, contact jane.lynch@oxfordshireccg.nhs.uk
This newsletter is for all health professionals in Oxfordshire and is written by the Medicines Management Team, Oxfordshire CCG, Jubilee House, Oxford Business Park South, Oxford, OX4 2LH

Mesalazine/Asacol MR switch to Octasa MR

Following a review of the literature, changes have been made to the recommendations on interchangeability of oral mesalazine preparations. The BNF now states that there is no evidence to show that any one oral preparation of mesalazine is more effective than another. Switching from prescribing generic mesalazine MR and Asacol® MR to prescribing Octasa® MR 400mg and 800mg tablets could save up to £60,000 per year in Oxfordshire.



So What?
For all new patients requiring oral mesalazine MR tablets, prescribe by the brand name Octasa® MR tablets 400mg and 800mg. Review all patients currently prescribed generic mesalazine MR 400mg and 800mg tablets or Asacol® MR 400mg and 800mg tablets for suitability to switching to branded Octasa® MR 400mg and 800mg tablets.
A template letter explaining the switch to patients and advising them to report any change in symptoms, is available from your Prescribing Advisor. This has been put together in conjunction with the gastroenterology team at the OUH

Ketone Testing: Why, Who and When

Oxfordshire has the highest rate of admissions for diabetic ketoacidosis (DKA) in England. Guidance is now available on the CCG intranet outlining information for GPs on providing ketone testing equipment to patients at risk. This is available here

The following patients should receive ketone testing strips:

- Insulin pump users (2 boxes)
- Patients with a history of admission with ketoacidoisis within the last 5 years (2 boxes)
- HbA1c >11% (97mmol/mol) or blood glucose often >20mmol/l (2 boxes)
- Pregnant patients with type one diabetes (2 boxes)
- Newly diagnosed type one diabetes (1 box)

The guidance also provides information for patients on sick day rules and what to do if ketone levels are high.

So what?
If patients are not under the care of OCDEM, GP responsibilities are:

- Provide on-going strips to patients initiated in secondary care
- Reinforce training on meter use
- Reinforce education on dealing with high ketone levels so that patients know what to do if levels are high.

Sildenafil – NHS prescribing

Following a Department of Health (DH) consultation, new NHS criteria for the provision of erectile dysfunction pharmacological treatments have been agreed. Generic sildenafil tablets can now be prescribed on the NHS for ANY patient with erectile dysfunction, regardless of cause, where this is clinically appropriate and no SLS endorsement will be required.

OCCG recommend that generic sildenafil is used first line for all ED patients, at a maximum frequency of dosing of four times a month. The lavender statement on the treatments for erectile dysfunction is currently being updated to reflect these changes and will be available shortly.

So what?
NHS prescriptions can now be written for generic sildenafil for all ED patients, if clinically appropriate. SLS restrictions still apply to all other phosphodiesterase type-5 inhibitors.

Dalteparin (Fragmin) in Intermediate and High Risk Pregnancy

GPs should start dalteparin for high and intermediate risk women **in advance** of seeing an obstetrician as the risk of thrombosis starts very early in pregnancy.

However, once an obstetrician has been seen, GPs can now continue to prescribe for both intermediate and high risk pregnancy (previously just high risk pregnancy).

This is shared care (yellow in traffic lights) for both high and intermediate risk and is reflected on the last page of the updated dalteparin guidance

So what?
Treatment for high and intermediate risk patients should begin as soon as possible after a positive pregnancy test and be continued until the patient attends their first appointment with the specialist, after which the GPs can take over the prescribing of dalteparin for high and intermediate risk patients.

Secondary Prevention of Fragility Fractures In Women and Men

This guidance has been updated to take into account the warnings from MHRA about increased cardiovascular risk with strontium. Strontium is restricted to the treatment of severe osteoporosis in postmenopausal women and adult men at high risk of fracture who cannot use other osteoporosis treatment due to for example contraindications or intolerances. In Oxfordshire there is a lavender statement recommending that it is low priority for use in men.

So What?
Updated guidance highlights the MHRA warnings about strontium. Treatment should only be started by a physician with experience in the treatment of osteoporosis. Treatment should not be started in people who have or who have had, ICH, PAD, CVD and uncontrolled hypertension. CV risk should be monitored every 6-12 months.

Salbutamol inhalers for use in schools

On the 1st October, an amendment was made to the Human Medicines Regulations 2012 to allow the supply of salbutamol inhalers to schools. This will allow schools to keep a stock of inhalers and spacers for emergencies. This is not mandatory and schools do not need to take part. Schools will need to purchase the inhalers (and spacers) themselves from a pharmaceutical supplier and it is recommended that five are kept in stock. GPs are not expected to provide the inhalers or additional prescriptions as a result of this change. The inhalers can only be used for children who have been diagnosed with asthma, and prescribed a reliever inhaler OR who have been prescribed a reliever inhaler for another reason. Parents will need to have given consent for the emergency inhaler to be used. The school will inform the parents if a child needs to use the emergency inhaler and the parents may then choose to inform the child's GP.

So what?
GPs should be aware of this change but are not expected to provide any additional support to schools as a result of it.

Nitrofurantoin – Use in Renal Impairment

The MHRA have updated their guidance on the use of nitrofurantoin in renal impairment. In a change to their previous advice, it is now recommended that :

- nitrofurantoin should not routinely be used in patients with an **eGFR of <45ml/min/1.73m^2** (previously contraindicated in patients with an eGFR of <60ml/min/1.73m2)
- A short course (3 to 7 days) may be used with **caution** in certain patients with an eGFR of 30 to 44 ml/min/1.73m^2 to treat lower urinary tract infection with suspected or proven multidrug resistant pathogens when the benefits of nitrofurantoin are considered to outweigh the risks of side effects.

After a review of the existing evidence, in the context of increasing resistance to alternative antibiotics and the risk of CDI with the widespread use of broad spectrum antibiotics, the MHRA concluded that the current contraindication is no longer supported and therefore nitrofurantoin will be available for use in a wider patient group than previously.

So what?
Nitrofurantion may now be prescribed in patients with a lower eGFR than previously recommended and therefore will now be an option for more patients. Nitrofurantoin is a first line option in the Oxfordshire Antimicrobial Prescribing Guidelines for Primary Care for treatment of all lower UTIs. The current recommended preparation for treatment is nitrofurantoin 100mg MR capsules.