Prescribing Points

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Oxfordshire Cinical Commissioning Group

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Oral Nutritional Supplement Prescriptions for Care Homes

At the September meeting of the Area Prescribing Committee (APCO), it was agreed that the classification of oral nutritional supplements (sip feeds), to residents within care and nursing homes, should be considered **BLACK** for prescribing in primary care, with the exception of patients suffering from **Motor Neurone Disease** or **head/neck cancer**. It is expected that these patients would have previously been assessed by a dietitian. This classification does **NOT** apply to patients receiving **sip feeds** via a **PEG tube**.

Regulation 14 of the Care Quality Commission (CQC) Guidance for Providers is very clear that homes are responsible for assessing and making the necessary arrangements for the provision of suitable nutrition and hydration for all residents. OCCG has therefore taken the decision that NHS funding should not be spent providing nutritional support to residents within homes. All care and nursing homes have facilities to prepare fortified meals and high energy snacks where disease-related malnutrition is present, as well as liquidised diets for residents with swallowing difficulties. The homes also have the option of purchasing "over the counter" supplements such as Complan® (Nutricia) or Nurishment® (Dunn's River).

In order for necessary arrangements to be put in place to support the homes, it is planned that the implementation date will be **1st December 2015**. All care and nursing homes within Oxfordshire will be notified of this decision and implementation date and will be given access to resources located in the care home section on the OCCG internet. These could be used to develop suitable food fortification and menu plans where needed. Additional advice may be obtained from the Care Home Support Service.

So What?

- As of 1st December 2015, sip feeds will be BLACK listed for prescribing in primary care, for residents of care / nursing homes, with the exception of patients with motor neurone disease, head / neck cancer and those receiving sip feeds via a PEG tube.
- Homes are responsible for providing suitable nutrition and hydration for all their residents
- Resources including lists of high calorie drinks and snacks, ideas for food fortification and recipes for homemade supplements will be available on the OCCGinternet
- Advice may be sought from the Care Home Support Service

Updated Guidance - Opioid Prescribing Guidelines for Non Cancer Pain

The Opioid Prescribing Guidelines have recently been updated in conjunction with the OUH pain unit and are now available on the CCG intranet here.

Opioid Prescribing Guidelines for Non Cancer Pain

Pain Ladder		
Step 1	Regular Paracetamol (use throughout pain ladder)	
Step 2	1st Line: Consider adding Codeine	Co-codamol or co-dydramol may also be an option.
	2nd Line: Switch to Tramadol if codeine is ineffective	
	On specialist recommendation only Buprenorphine Patches ○ Butrans Only for patients with stable pain who have swallowing difficulties and cannot tolerate other options. Not to be used for any other patient group.	
Step 3	1st Line: 1. Morphine ○ Modified Release: Zomorph Capsules *(can be opened if swallowing difficulties)* or Morphgesic tablets. ○ Standard Release: Sevredol tablets or Oramorph liquid	ONLY change from 1st line treatment with Morphine if side effects are intolerable (NB nausea may lessen after a few days) or rarely for a trial of opioid switching. Only use more than one prolonged release opioid on specialist advice. **Doses over 120mg-180mg of morphine (or equivalent) daily should be referred to a specialist.**
	2nd Line: 1. Oxycodone ○ Modified Release: Longtec ○ Standard Release: Shortec 2. Fentanyl Patches * ○ Fencino	Oxycodone is the first choice of these treatments, to be used only if patient is intolerant to morphine. **Note: Oxycodone is roughly double the potency of morphine** *Fentanyl patches would be the next choice IF the patient has stable pain and is unable to take medication orally, making the other options unviable. **Please note that fentanyl is a very strong opioid, e.g. 50mcg/hr patch = 120mg morphine daily (see table in fentanyl section for full dose equivalents)**
Break Through Pain	Standard release morphine (Sevredol or Oramorph) or standard release oxycodone (shortec)	

The updated pain ladder is shown opposite, with the main changes being:

- Inclusion of buprenorphine patches, on **specialist recommendation only**, for patients at step 2 who have swallowing difficulties and cannot tolerate other options
- Clarification of when the dose of morphine taken daily warrants referral to a specialist.
- Clarification of potency of oxycodone and fentanyl and equivalent morphine dose

Key points in full guidance

- Morphine should be considered first-line if a **strong** opioid is indicated.
- The BNF states that oxycodone has an efficacy and side effect profile similar to morphine. Oxycodone may be considered an alternative to morphine in the small proportion of patients who develop intolerable adverse effects.
- Buprenorphine patches are broadly as effective as codeine or tramadol but much more expensive. Reserved for use on specialist advice only for patients who have swallowing difficulties and cannot tolerate other options
- Fentanyl patches should only be used in patients with stable pain who cannot take oral opioids. They should only be used at stage 3 as a secondary option. Fentanyl patches contain a very strong opioid; care must be taken when selecting the correct strength of patch.
- Opioids can be effective in the management of somatic, visceral and neuropathic pain.
- Opioids are prescribed to reduce pain intensity. Data demonstrating sustained analgesic efficacy in the long term are lacking.
- Complete relief of pain is rarely achieved with opioids. The goal of therapy should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning.
- 80% of patients taking opioids will experience at least one adverse effect. These should be discussed with the patient before treatment begins.
- Opioids should not be used as first line pain therapy if other evidence-based interventions are available for the condition being treated.
- Drugs with demonstrated efficacy for persistent pain syndromes (e.g. tricyclic antidepressants and antiepileptic drugs for neuropathic pain) should always be prescribed before starting opioids.

Medication supply issues and price increases

Drug	Price increase/supply issue	Alternative	Alternative price
Locorten-Vioform ear drops	Branded product has been discontinued and replaced by a generic at a much higher cost (£10.37 per bottle)	Otomize ear spray or Sofradex ear drops depending on availability and infection treated	Otomize - £3.27 Sofradex - £7.50
Fucithamic eye drops	Branded product has been discontinued and replaced by a generic at a much higher cost (£29.06 per tube)	Chloramphenicol eye drops/ointment	Drops - £1.53 Ointment - £1.98
Lacrilube eye ointment	Product has been recalled leaving stocks in supply chain limited	Xailin night ointment	£2.49 for 5g tube
Nitrofurantoin 100mg MR capsules	Supply limited	Nitrofurantoin 50mg tablets/capsules standard release	Tablets - £11.78 for 28 Capsules - £15.42 for 30
Antepsin® (Sulcralfate) 1G/5ml suspension & 1G tablets	Manufacturer expects resolution of UK licensed stock availability in 2016. More information here	No new patients should be initiated. Specials are available but at a much higher cost	Specials are costing up to £600 for liquid and up to £300 for tablets
Zovirax® (aciclovir) eye ointment	Manufacturer states out of stock with no resolution until 2016	Ganciclovir 0.15% ophthalmic gel is available as an alternative	£19.99 for 5g tube
Co-Proxamol (NB licensed withdrawn in 2005 – has only been available on named patient basis since)	No further UK stock available. Manufacturer unable to confirm if further stock with be available in the future.	Alternative analgesic such as co-codamol. A special import may be available but at a much higher cost	£4.11 for 100 co-codamol 30/500 tablets. Co-proxamol import £49.50 for 100

Patient leaflet giving advice on a suggested trial of stopping overactive bladder drugs

There is now a leaflet available for patients who would benefit from a trial of stopping their antimuscarinic drug for overactive bladder, this includes a bladder diary to record symptoms and side effects when taking the medication and after stopping to help them decide if the treatment is still of benefit. The leaflet can be found on DXS and on the CCG intranet here

MHRA Drug Safety Update –Mirabegron: risk of severe hypertension and associated cerebrovascular and cardiac events

The MHRA have recently issued drug safety information on the use of mirabegron.

Mirabegron is now contraindicated in patients with severe uncontrolled hypertension; advice about regular monitoring is being introduced because of cases of serious hypertension.

Key updated safety advice for healthcare professionals:

- Mirabegron is contraindicated in patients with severe uncontrolled hypertension (systolic blood pressure ≥180 mm Hg or diastolic blood pressure ≥110 mm Hg, or both)
- Blood pressure should be measured before starting treatment and monitored regularly during treatment, especially in patients with hypertension
- Please report suspected side effects to mirabegron on a Yellow Card

Please note that, mirabegron is restricted for use on specialist advice only and therefore should not be initiated in primary care. The local guidelines on the treatment of overactive bladder are available here

Guidelines for acute and prophylactic treatments in migraine

New local guidelines have been developed by a local GP and the neurology team giving advice on the current therapies available for the prophylaxis and treatment of migraine. These can now be found on the CCG intranet here

The acute guidance focuses on pharmaceutical treatments available including analgesics, triptans and anti-emetics, as well as some general advice on lifestyle factors and the efficacy of treatments.

The prophylactic guidance discusses the pharmaceutical options available and the rationale behind each, as well as some further lifestyle advice, alternative therapies and when a referral is necessary; including what treatments may then be used in secondary care.

So What?
Prescribers should be aware of the new guidance and may wish to reference it when treating a patient with acute migraine, offering a prophylactic therapy or considering a referral.

Melatonin – An Update

Since providing information on the prescribing of melatonin within primary care in Prescribing Points June 2015, there have been several questions raised around potentially inappropriate requests from secondary care clinics.

After discussions between OCCG and OUH it has been agreed that no new requests are to be sent to GP practices for provision of melatonin until a time when suitable material is taken to APCO for discussion and potential approval. Oxford Health (CHAMHS) have agreed to provide prescriptions for patients under their care or initiated by them. If practices receive any such requests please deal with these as you would any other inappropriate request via DATIX and forward any information to ross.burton@nhs.net.

Specialist antibiotics – linezolid and fosfomycin

There has been an increase in prescriptions written in primary care for antibiotics that are classified as specialist only and therefore should only be used in secondary care under the care of an infectious diseases consultant.These drugs are specialist only to help to reduce the risk of resistance developing by limiting use. Linezolid is associated with blood disorders so needs careful monitoring it is also very expensive costing £445 for 5 days treatment.

So What?
If linezolid or fosfomycin are the only oral options on a sensitivity report prescribers should contact the on call microbiologist for advice. Secondary care should arrange to supply the drug if needed.

Prednisolone 1mg/ml oral solution (prednisolone Dompe) 5ml single dose units

The cost of prednisolone 5mg soluble tablets has risen in recent years and is now £53.48/30 tablets. Prednisolone 1mg/ml oral solution (prednisolone Dompe) 5ml single dose units cost £11.41/ 10 unit doses so offer a cost effective alternative. It should be prescribed as prednisolone 5mg/5ml oral solution unit dose on Emis Web to avoid an expensive special being inadvertently ordered. We have had some reports that pharmacies are struggling to source this product but have been informed by the company that it is available from AAH and the pip code is 1202472.

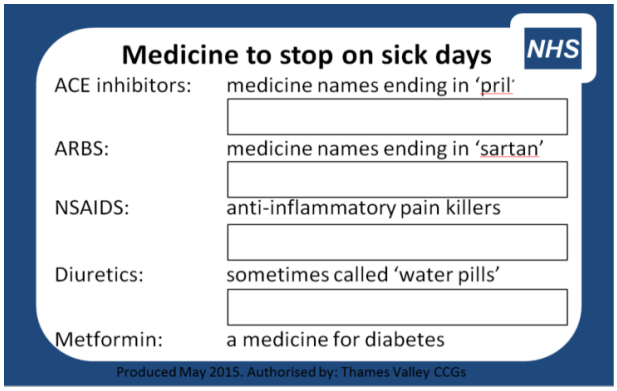
Acute Kidney Injury – Medicine Sick Day Rules Patient Cards

Dehydration can be a significant risk for people taking certain medicines. If these medicines are continued while a person is dehydrated, there is an increased risk of adverse outcomes, significantly an increased risk of acute kidney injury (AKI).
AKI is a clinical syndrome that is common, harmful and often avoidable. It encompasses a spectrum of injury from minor changes in kidney function to acute failure requiring renal replacement therapy.
The main risk factors for development of AKI are:

- Age over 65yrs
- Nephrotoxic drugs (particularly NSAIDs, ACE-I/ARBs, diuretics)
- Previous AKI
- Chronic kidney disease
- Heart failure
- Diabetes
- Liver Disease
- Severe diarrhoea

AKI, irrespective of severity, increases the risk of chronic kidney disease and further episodes of acute injury. It is associated with greater use of healthcare resources, including an increase in frequency, intensity and duration of hospitalisation, at an estimated annual cost of over £1 billion in England. In Oxfordshire there were 365 AKI admissions between January and December 2014 at a cost of £1.3 million.

AKI often starts in the community when a vulnerable patient develops an inter-current illness such as diarrhoea, vomiting or infection which leads to dehydration. Recent National Institute for Health and Care Excellence (NICE) guidance on acute kidney injury focuses on improving the management of episodes of these acute illness including the use of 'medicine sick day rules' that recommend the temporary cessation of potentially nephrotoxic drugs. This is especially important in patients who already have some level of renal impairment or are taking more than one of these medicines.
One scheme, originally developed by NHS Highland, aimed to promote 'sick day rules' by providing credit card sized patient information cards to those who may be at risk, and similar cards (see below) have now been developed for use across Thames Valley with input from local renal consultants, GPs and pharmacists.



So What?
Cards will be supplied to all GP practices and pharmacies in Thames Valley over the next month and can be given to 'at risk' patients during a consultation. They should not be available for self-selection. Patients should also be counselled on the importance of maintaining good fluid intake when unwell and that medicines should be restarted once they are better. Encourage the patient to contact the practice/pharmacy if they are ever unsure about what they should do.
More information on AKI is available on the 'Think Kidneys' website https://www.thinkkidneys.nhs.uk/