Prescribing Points

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Oxfordshire Cinical Commissioning Group

This newsletter is written by the Medicines OptimisationTeam, Oxfordshire CCG, Jubilee House, Oxford Business Park South, Oxford, OX4 2LH. It is for all health professionals in Oxfordshire and is uploaded to the OCCG website. Please let us know if you are receiving this newsletter and it is no longer relevant to you by contacting Sue Keating, Team Administrator, on susan.keating@oxfordshireccg.nhs.uk.

Update to Oxfordshire Adult Antimicrobial Prescribing Guidelines

The Oxfordshire Antimicrobial guidance has been updated to include the following:

- FeverPAIN as an option to use as an assessment tool to use for acute sore throat
- Nitrofurantoin use in renal impairment updated in line with MHRA guidance.

Nitrofurantoin is now contraindicated in renal impairment (eGFR less than 45 ml/min/1.73m2). For eGFR 30-45: only use if resistance & no alternative (previously contraindicated if eGFR < 60ml/min/1.73m2)

- addition of **pivmecillinam** for UTI to full guidance in line with local UTI guidance updated in 2015
- addition of trimethoprim for pyelonephritis (is MSU shows susceptibility) in line with local UTI guidance
- change to choice of first line antibiotic for empirical treatment of first episode of Clostridium difficile infection (CDI) from vancomycin to **metronidazole** in line with national guidance

Note: vancomycin remains the treatment option of choice for a second episode or a recurrence. More information on treatment of suspected CDI is available here

- addition of **clarithromycin** as an option to treat mild cellulitis in patients with penicillin allergy in line with national guidance

The updated guidance is available on the CCG intranet here and the CCG website here. They have also been added to DXS.

So What?
Prescribers should ensure that they are using the most up-to-date version of the antimicrobial prescribing guidelines and note the changes that have been made in this update.

Oxfordshire HRT formulary and treatment guidance

The Oxford Menopause Service, based at Oxford University Hospitals, has developed a HRT formulary and treatment guide to aid decision making when initiating HRT. It is now available on the CCG intranet here. The guideline covers the following areas:

- Formulary (1st and 2nd line choices and reasons for choice)
- Diagnosing menopause and need for treatment
- Contraindications, cautions and risks of HRT
- Considerations associated with HRT
- Premature ovarian insufficiency/premature menopause
- When to refer

This is in line with the recent NICE menopause guidance published in November 2015.

So What?
Prescribers should be aware of the new guidance when initiating patients on HRT or when reviewing medication choices.

Prescribing of sip feeds for residents in care and nursing homes

In the October edition of the Prescribing Points, practices were advised that, as from 1st December 2015, sip feeds are to be considered as **BLACK** listed for prescribing (in primary care only) for residents in care and nursing homes. To clarify, this guidance does **NOT** apply to:

- patients who receive feeds via a percutaneous endoscopic gastrostomy tube (PEG tube)
- patients suffering from head / neck cancer or
- patients with motor neurone disease

In addition, this guidance **ONLY** applies to patients living in fully catered care and nursing homes and **NOT** those patients residing in care homes where they live either independently or with carer support. A patient information leaflet (PIL) has been prepared to explain the rationale behind the decision to black list sip feeds and to explain what the alternative options are. The PIL is available to be handed out to patients and their relatives who require information about the recent decision and can be accessed via the Oxfordshire Clinical Commissioning Group (OCCG) Website and will also be available on DXS.

For clarification of the guidelines, please ask a member of the CCG Medicines Optimisation Team. Queries regarding individual patients should be directed to the Care Home Support Service, unless the patient is already under the care of the dietitians.

Oxfordshire Solar Keratosis Primary Care Treatment Pathway

A solar keratosis treatment pathway has been developed locally by the dermatologists for use in primary care. It is now available on the intranet here and covers:

- Diagnosis and patient pathway (photos of various types of solar keratosis included)
- When to treat and when to refer
- Skin cancer risk
- Topical treatment option (see below table)

Offer topical treatment-

1st line - 5-Fluorouracil cream (Efudix®) Apply once or twice daily for 3 to 4 weeks, depending on site. Counsel regarding skin reaction (give Eumovate® if symptomatic).

2nd line - Ingenol mebutate gel (Picato® ▼) For patients unable to tolerate/comply with Efudix
• on face and scalp lesions, apply 150 micrograms/g gel once daily for 3 days
• on trunk and extremities, apply 500 micrograms/g gel once daily for 2 days

3rd line – imiquimod 5% cream (Aldara ®) To be used if Efudix® and Picato® are not tolerated or if there is field change (refer to specialist if needed). Apply to lesions 3 times a week at night (wash off after 8 hours)for 4 weeks; assess response after a 4 week treatment –free interval; repeat 4 week course if lesions persist; maximum 2 courses.

So What?
The new guidance clarifies when treatment could be started in primary care and what the formulary choices available are.

Antipsychotic-induced hyperprolactinaemia - Guideline for identification, monitoring and management

Since 2010 Oxford Health NHS FT has had a guideline for the identification, monitoring and management of antipsychotic (AP)-induced hyperprolactinaemia. In 2015 a significant revision to the guideline was issued. The guideline applies to all ages up to 50 years in females and 65 years in males. It remains important to take a baseline prolactin (PRL) level in anyone commencing a PRL raising AP but the current edition places heavy emphasis on symptom enquiry in adults (e.g. taking adequate menstrual histories in women and asking about sexual dysfunction in men and women) rather than carrying out (often unnecessary) repeat PRL measurements. In children and adolescents repeat PRL measurements are necessary.

All antipsychotics have the potential to raisePRL. The degree to which they have this effect varies significantly. In general, antipsychotics considered as "PRL raising" are: amisulpride, risperidone, paliperidone, olanzapine, and all first generation (typical) antipsychotics (e.g. haloperidol, trifluoperazine, flupentixol, sulpiride etc.).
Some people with raised PRL are asymptomatic. Others may experience problems including breast enlargement, galactorrhoea, reduced libido, erectile dysfunction, amenorrhoea, or anorgasmia. In children and adolescents hyperprolactinaemia can lead to pubertal delay. An indirect longer term risk of raised PRL is osteoporosis. The percentage of men who develop hypogonadism as a result of antipsychotic induced hyperprolactinaemia is uncertain but probably low, however approximately just over two thirds of women with antipsychotic induced hyperprolactinaemia develop hypogonadism (as defined by amenorrhoea). Suppression of gonadal function is the main mechanism behind the development of osteoporosis with hyperprolactinaemia. A woman who is amenorrhoeic due to hyperprolactinaemia is more at risk of low bone mineral density (BMD) than someone who is menstruating despite hyperprolactinaemia, because amenorrhoea indicates very low oestrogen levels. The longer the duration of the amenorrhoea, the greater the BMD loss. For men, a 9am testosterone level below the normal range is the indicator of an increased risk of low BMD.

The guideline is available here. For further advice please contact Oxford Health's Medicines Information Service (01865 904365 or med.info@oxfordhealth.nhs.uk).

Medication supply issues and price increases

Drug	Price increase/supply issue	Alternative	Alternative price
Univer® 120mg, 180mg & 240mg capsules (Verapamil SR)	Out of stock due to an unexpected delay in a move new manufacturing site. Univer® 120mg Caps – currently out of stock Univer® 180mg Caps – currently out of stock Univer® 240mg Caps – out of stock from early March 2016	Use SR *tablets* instead. Only available in 120mg and 240mg	120mg SR tablets: £7.71 (28) 240mg SR tablets: £5.55 (28) (in comparison SR caps: 120mg - £4.86, 180mg - £11.38, 240mg - £7.67 all for 28)
Pioglitazone (all strengths)	Some supply issues with generic product. Price concession has been in place since December increasing the cost.	Prescriptions are currently being reimbursed at branded product cost	Pioglitazone 15mg tablets (28) - £25.83 (previously £1.08) Pioglitazone 30mg tablets (28) - £34.99 (previously £1.31) Pioglitazone 45mg tablets (28) £39.55 (previously £ 1.47)

DMARD Shared Care Protocols

The DMARD shared care protocols have recently been updated and can be found on the intranet under shared care. The following drugs are YELLOW for certain indications on the traffic lights so must **only** be prescribed under shared care:

- Azathioprine
- Ciclosporin
- Hydroxychlorquine
- Leflunimomide
- Mercaptopurine (available shortly)
- Methotrexate
- Mycophenolate
- Penicillamine
- Sodium Aurothiomalate (Gold)
- Sulfasalazine

The document Shared Care Responsibilities outlines the responsibility of the Specialist, the GP and the patient. GPs should not agree to shared care ofa patient if they do not have the appropriate information from secondary care. If a copy of the shared care protocol is not sent with the request, it is available on the intranet and DXS for reference. Any incomplete or inappropriate requests should be reported on Datix as soon as possible.
Work is being initiated with secondary care to improve the process at the initiation stage.

So What?
Prescribers should be aware of Yellow shared care drugs. Starting inappropriate or incomplete requests can have potentially fatal consequences for patients. Help the OCCG assess the situation by filling out Datix reports or making your prescribing adviser aware of any issues.

Levonorgestrel-releasing intrauterine systems: prescribe by brand name

The MHRA have highlighed that Levonorgestrel-releasing intrauterine systems should always be prescribed by brand name because products have different indications, durations of use, and introducers.

Products containing 52 mg levonorgestrel: A levonorgestrel-releasing intrauterine system (IUS) has been available as the brand Mirena for a number of years. Recently, a second product called Levosert was licensed for use in the UK. Although Mirena and Levosert both contain 52 mg levonorgestrel, they differ in 2 important ways:
Indications for use

- Mirena is licensed for 5 years' use and Levosert is licensed for 3 years' use in the indications of contraception or heavy menstrual bleeding. Clinical data for long-term efficacy and safety of Mirena for contraception and heavy menstrual bleeding are available for 5 years of use, whereas 3 years of data are currently available for Levosert
- Mirena is also licensed for 4 years' use for endometrial protection as part of a hormone-replacement therapy regimen (Levosert is not licensed for this indication)

Introducer or insertion device

- Mirena and Levosert have different introducers, requiring different insertion techniques. Insertion (and removal) of any intra-uterine device (IUD) may be associated with pain, bleeding, and (in some cases) perforation of the uterus. Therefore, IUDs should only be inserted by healthcare professionals who are experienced in insertion or who have had training in the relevant insertion techniques

Product containing 13.5 mg levonorgestrel: A smaller IUS that contains 13.5 mg levonorgestrel (called Jaydess) has been marketed since 2014 and is licensed for 3 years' use for contraception only. Note the advice for insertion above also applies to this product.

So What?
Ensure that the brand is specified when prescribing an IUS. Jaydess and Levosert have not yet been added to the Oxfordshire formulary.

CHA_2DS_2-VASc score calculators on EMIS Web

NICE advises clinicians to use the CHA_2DS_2-VASc stroke risk score to assess stroke risk in people with any of the following:

- symptomatic or asymptomatic paroxysmal, persistent or permanent atrial fibrillation (AF)
- atrial flutter
- a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm

The calculator works on the basis of "awarding" points for the presence of risk factors for stroke (see below). A patient's CHA_2DS_2-VASc score may be calculated either manually or by using an on-line CHA_2DS_2-VASc calculator. Alternatively, CHA_2DS_2-VASc scores can be calculated using the template available on Emis Web, where each risk factor is automatically identified by the presence of certain read codes.
During a recent audit of stroke prevention in AF patients, it became clear that some patients with a diagnosis of hypertension, were not being awarded a "point" for this risk factor. This resulted in their CHA_2DS_2-VASc scores being artificially low, which could potentially affect the decision whether to anticoagulate. Correspondence with Emis Web revealed that the CHA_2DS_2-VASc score calculator uses the same definition for hypertension as QRisk. This means that in order for a patient to fulfil the correct criteria for hypertension he / she must have not only diagnosed hypertension but also be prescribed one or more of the four main antihypertensives.

Risk factors for Stroke	Points
Age 65 – 74yrs	+1
Age ≥ 75yrs	+2
Female	+1
Congestive heart failure history	+1
History of hypertension	+1
Stroke / TIA / Thromboembolism history	+2
Vascular Disease history	+1
Diabetes mellitus	+1

So What?
Clinicians should consider that for patients with AF and a diagnosis of hypertension, their CHA_2DS_2-VASc score calculated by Emis Web may be artificially low if they are not prescribed antihypertensive medication.

Patient Group Directions (PGDs) for travel vaccines

The PGDs for Typhoid, Hepatitis A and Hepatitis B expired at the end of October 2015. These have not been updated as it is expected that NHS England South will be providing PGDs for these vaccines shortly. In the meantime, practices should ensure a patient specific direction is in place when a non-prescriber is administering these vaccines – some useful information on PSDs and PGDs for practices is available on the BMA's website here.

AirFluSal Forspiro dry powder inhaler

AirFluSal Forspiro is a new branded generic dry powder inhaler containing 500mcg fluticasone and 50mcg salmeterol. It is only licensed for patients with COPD. It is equivilent to Seretide 500 accuhaler and the device is similar in shape and colour but offers a reduction in cost of 20%.
A Fluticasone/salmeterol dry powder inhaler is no longer included in local COPD prescribing guidance (May 2015) however, as historically it was one of the first line choices if an inhaled corticosteroid/long acting beta agonist combination was indicated, then prescribing rates in the county remain high. The Area Prescribing Committee have therefore agreed that **only patients currently prescribed Seretide 500 accuhaler for COPD** should be switched to AirFluSal Forspiro. This offers a potential saving across the county of approx. £180k per year and will also be in line with the OUH formulary choice.

So What?
Suitable COPD patients already prescribed seretide can be switched to AirFluSal Forspiro (prescribe by brand). Please contact your prescribing advisor if you require any help with implementing this.