CITY SCRIPTS

Brighton and Hove Clinical Commissioning Group

Prescribing Newsletter July/August 2014

This newsletter is produced by the Medicines Management Team at the CCG, and is sent to all local GPs, Practice Nurses and Community Pharmacists. We would welcome any feedback on the content and usefulness of the newsletter and suggestions for future topics.

Medicines Management Team Update

Barbara Pawulska has started her 12 month sabbatical in the Central African Republic (CAR) working as a pharmacist for **Médecins Sans Frontières** (MSF). Whilst Barbara is missed by her practices and the Medicines Management Team, we are pleased to say that Fionnuala Plumart will be covering this sabbatical and starts in September. Fionnuala currently works as a clinical pharmacist at BSUH and will be on secondment with us for 12 months. In the meantime any queries form Barbara's practices should be emailed to BHCCG.MedicinesManagement@nhs.net

Prescribing Support Technician, Ross Glennie has moved on to pastures new and Jade Tomes is now in post as Specialist Pharmacy Technician managing the operational running of the Brighton Area Prescribing Committee (APC). We are therefore delighted to welcome two new prescribing support technicians to our team; Samantha Durrant and Nick Rutherford. They will soon be out working in practices to support the medicines optimisation programme.

Updated Antibiotics guidance on the Joint Formulary

Updated primary care antibiotic guidelines 2014 are now on the website. They have been adapted from the HPA template, with advice from BSUH microbiologists.
The guidelines include advice for dental infections, shingles, threadworm and conjunctivitis. Other changes include:

- Fewer indications for co-amoxiclav in line with local priorities to reduce C.diff rates
- Fewer indications for clarithromycin due to common drug interaction, doxycycline replaces it in many cases
- Vancomycin has now replaced metronidazole as 1st line for C. diff infection

BSUH Microbiology advice on Mixed Infections or Source of Infection Unknown

If an infection is mixed or source unclear at the time of initial patient presentation the advice would be to use two antimicrobials rather than relying on co-amoxiclav to cover both possible infections. For example::

- For chest & urine - amoxicillin + nitrofurantoin or trimethoprim
- For cellulitis & urine - flucloxacillin + nitrofurantoin or trimethoprim

- Oral cephalosporins do not penetrate lung tissue well and are not suitable to treat chest infections. In the case of penicillin allergy, the recommendation would be doxycycline 200mg stat then 100mg daily for 5-7 days depending on the condition being treated.
- For skin & soft tissue infections e.g. cellulitis, flucloxacillin 500mg four times a day monotherapy is advised (unless penicillin allergy whereby clarithromycin 500mg twice daily is recommended
- Flucloxacillin monotherapy is the antibiotic of choice when treating confirmed methicillin-sensitive staphylococcus aureus (MSSA) infections. Although co-amoxiclav is active against MSSA infections the additional spectrum of cover is usually not necessary.

Mupirocin Supply Problem

There is a national shortage of mupirocin. Octenisan nasal gel should be used TWICE daily for 5 days as an alternative when mupirocin is usually recommended e.g. as pre-surgery suppression therapy for MRSA positive patients.

Joint Formulary

Brighton APC makes decisions concerning additions to the Joint Formulary. The following summarises decisions made by the APC in May 2014:

- We no longer recommend Feldene / piroxicam gel and preference is Fenbid 5% ibuprofen gel

Preparation	Decision	Notes
Triptorelin	Added to joint formulary as **GREEN**	6 monthly injection available
Fosfomycin Oral	Added to joint formulary as **BLUE**	Unlicensed. ONLY upon recommendation of microbiology.
Glucophage sachets (Metformin)	**Removed** from joint formulary	Sachets have been discontinued by manufacturer. Liquid to be used for patients with swallowing difficulties only.
Metformin 500mg/5ml liquid	Added to joint formulary as **GREEN**	
Fultium D^3 3,200 IU capsules	Added to joint formulary as **GREEN**	Once a day higher strength
Evacal D^3 chewable tablets	Added to joint formulary as **GREEN**	This is the preferred chewable preparation of calcium/colecalciferol which is to replace the prescribing of Adcal D^3 in primary care.
Doublebase Gel	**Removed** from joint formulary	An extension to the Zero range. Equivalent product to doublebase.
Zerodouble Gel	Added to joint formulary as **GREEN**	

Wound Care ONPOS Update

- All requests for dressings that are listed on the Wound Care Formulary are to be ordered through ONPOS, even for patients who normally pay for prescription charges. Such supplies will not incur a prescription charge.
- Dressings ordered through ONPOS should not be included on the patients' repeat medication records, thereby minimising the risk of inadvertently ordering via FP10 route. It is be advisable to note the dressings ordered / supplied in the consultation, for complete record keeping.
- The only exception to the ONPOS route is for those small numbers of patients who do not visit the practice nurse and are self-managing at home. These patients can still have their dressings via FP10 route, and if it is long term therapy, it may be appropriate to put them on repeats with adequate review dates in place.

Action: Review all patients who have dressings on repeats with the view to following the above advice

Constipation in children and young people NICE Quality Standard (QS62)

NICE Quality Standards (QS) are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care.

QS62 covers the diagnosis and management of **idiopathic constipation in children and young people** (from birth to 18 years). It covers assessment, **first-line treatment with a macrogol**, disimpaction therapy, review and referral for non-responders to initial treatment. Written information regarding laxative treatment should be provided when treatment is started.

The quality Standard is summarised in the NICE Pathway Constipation in children and young people which links all guidance related to this topic in an easy-to-navigate format.

Feedback from Community Pharmacy Anticoagulant Monitoring Service (CPAMS)

Recently, two patients seen at CPAMS had an INR reading of over 8.

The attributed factors included a course of steroids in one case, whilst the other unwell patient had their dose of bumetanide increased.

Action: Patients on warfarin who have had their therapy changed, should be advised to contact their anticoagulant monitoring clinic for advice on the need for additional INR

MHRA Drug Safety Update

June 2014

Combination use of medicines from different classes of renin-angiotensin system blocking agents: risk of hyperkalaemia, hypotension, and impaired renal function—new warnings

- On the basis of current evidence, dual RAS blockade therapy through the combined use of ACE-inhibitors, ARBs or aliskiren is not recommended in any patient. In particular, ACE-inhibitors and ARBs should not be used concomitantly in patients with diabetic nephropathy, and existing contraindications on the use of aliskiren with either an ARB or an ACE inhibitor in patients with diabetes mellitus or moderate to severe renal impairment (GFR < 60 ml/min/1.73 m2) are confirmed.
- In individual cases where combined use of an ARB and ACE inhibitor is considered absolutely essential, it must be carried out under specialist supervision with close monitoring of renal function, electrolytes and blood pressure.
- Such supervised use would include the licensed use of candesartan or valsartan as add-on therapy to ACE inhibitors in patients with heart failure. However, in patients with chronic heart failure, dual blockade should be limited to those intolerant to mineralocorticoid antagonists and with persistent symptoms despite other optimal therapy.

These recommendations are based on a detailed review of the available data, including clinical trials, meta-analyses and publications, as well as advice from a group of experts on cardiovascular medicine.

Action: GPs to review notes of patients on dual RAS blockade in the first instance, and if unsure of what action to take, seek advice/ opinion from specialist / specialism that initiated therapy

July 2014

Transdermal fentanyl patches: reminder of potential for life-threatening harm from accidental exposure, particularly in children

Accidental exposure to transdermal fentanyl can occur if a patch is swallowed or transferred to another individual.

Children are at risk as they may touch, suck, chew, or swallow a patch that has not been disposed of properly. Also, children have a lower threshold for fentanyl overdose than adults.

Action: Healthcare Professionals are reminded to provide clear information to patients and caregivers regarding risk of accidental patch transfer and ingestion of patches, and need for appropriate disposal of patches. Advise patients and caregivers to follow the instructions on the patch carton and in the accompanying leaflet. If a patch is transferred to another person, it should be removed and the individual should get medical help immediately. If a patch is swallowed, the individual should get medical help immediately. The MHRA have produced a useful leaflet for patients on the following link.

www.mhra.gov.uk/home/groups/dsu/documents/publication/con437440.pdf

Prescribing Incentive Scheme (PIS) 2014-15 – Clarification and Update

The following errors in the original PIS 2014-15 document have been identified and a corrected version is available on the website:

- Total number of points in the PIS 2014-15 is 12 points and not 11 as originally noted
- The Benzodiazepine and Z drug Target will be based on a move towards a 30% reduction in ADQ/STAR PU13 [from October – December 2013 level] or less than (<) to the national average for October – December 2013 (2.70), whichever is higher.
- A data collection form for the High Dose Inhaled Corticosteroid in Asthma Review with the summary page has been added to the appendix and is available on the website, as are the other respective submission and data collection forms