# CITY SCRIPTS

Brighton and Hove Clinical Commissioning Group

## Prescribing Newsletter February 2013

This newsletter is produced by the Medicines Management Team at the PCT, 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.

## PIS Reviews and QOF Meds Man Indicator 10 evidence submission deadline

General Practices are reminded of the submission deadline of **28th February 2013** for the Prescribing Incentive Scheme (PIS) Submissions and QOF Medicines Management Indicator 10 evidence of 3 agreed action points

## What's new on the website:

### Pregabalin Prescribing Policy – December 2012

There is increasing evidence that pregabalin is abused and traded illicitly, with multiple reports from various local agencies, including drug workers, the needle exchange service, hostels and A&E. There is difficulty in managing this as the drug has a number of legitimate licensed indications.
This local policy supports clinicians in not prescribing pregabalin to patients with a history of substance misuse.

**Perinatal Mental Health Guidance** is a concise, practical guide to treating mental health problems, with a focus on the relative risks of prescribing drugs used to treat mental health problems during pregnancy and breastfeeding.

## Discontinued products

- The branded products Fersamal® (ferrous fumarate 210mg tablets) and Eltroxin® (levothyroxine) have being discontinued. However, generic preparations remain available.
  **Action:** ensure repeat prescriptions for Fersamal® and Eltroxin® are updated to their generic names
- **Tredaptive®** (fixed dose niacin-laropiprant ) was recalled in January 2013 following data from HPS2-THRIVE showing that risks out-weight benefits. Risks included a higher frequency of bleeding (intracranial and gastro-intestinal), myopathy, infections and new-onset diabetes
  **Action:** Patients currently taking Tredaptive® should make a non-urgent appointment to discuss their treatment options with their doctor.
  **Editors' note:** This is an example rather like the rosiglitazone, where Disease Orientated Outcomes (i.e improved lipid profile) does not translate to Patient Orientated Outcomes (reduction in morbidity / mortality)

## Shortage of normal release Isosorbide Mononitrate tablets (10mg, 20mg and 40mg), may last several months. We are therefore recommending the following switches to Isotard® XL **modified release** range of tablets (which are **unaffected):**

| Normal Release | Switch to Modified Release* |
|---|---|
| Isosorbide mononitrate 10mg twice daily | Isotard® 25mg XL tablets once daily |
| Isosorbide mononitrate 20mg twice daily | Isotard® 40mg XL tablets once daily |
| Isosorbide mononitrate 40mg twice daily | Isotard ® 60mg XL tablets once daily |

*Further **dose adjustments** may be necessary based on **clinical response**.

**Action:** Clinicians and Pharmacists should be **aware** of this shortage and work together to ensure continuity of an appropriate, cost-effective licensed treatment

## Community acquired C.difficile – a PPI connection?

Of the 27 confirmed C.difficile cases reported in the first 6 months of 2012-13, 15 were considered community acquired. Many of these had no apparent connection with broad spectrum antibiotics, but 50% of the patients affected had been taking lansoprazole 30mg long term.
Though not as strong as with broad spectrum antibiotics, the link between PPI use and C.difficile infection is well documented and appears to be dose related.

**Action:**

- When prescribing PPIs, it is important to use the lowest dose possible, with regular reviews to consider: dose reduction or the need for continued use. 24 out of the 47 General practices prescribe more than 50% of their lansoprazole in the 30mg strength, indicating a need for review
- BSUHT Guidelines for Prescribing Proton Pump Inhibitors (PPIs) in Adults is a useful resource (NHS connection required)

## Drug effects on QTc interval

Many commonly prescribed drugs are associated with prolongation of QTc interval, with recent warnings about citalopram, escitalopram, domperidone. These warnings are accompanied by advice to check ECG, but there is little information about when to check or how to act on the results. It is also not clear which drugs and drug combinations warrant an ECG check. Clinicians might find the following points useful:

- Prolonged QTc interval can lead to torsade de pointes which may lead to life-threatening ventricular arrhythmias.
- The degree of QTc prolongation at which torsade de pointes is likely to develop is uncertain, though it is generally accepted that a figure of 500milliseconds is of particular concern.
- There is also uncertainty about what constitutes an important change in QTc interval from baseline, although, in general, increases of 30 to 60 milliseconds should raise concern, and increases greater than 60 milliseconds raise clear concerns about the potential for arrhythmias.
- The consensus of opinion is that the concurrent use of drugs that have a high risk of prolonging the QTc interval should be avoided because of the risk of additive effects. However, under certain circumstances concurrent use may be unavoidable. In this situation **close ECG monitoring**, and a careful consideration of other risk factors present is essential.
- **Other risk factors** include: increasing age, female sex, congenital long QT syndrome, cardiac disease, thyroid disease, some metabolic disturbances (hypocalcaemia, hypokalaemia, hypomagnesaemia)

The following table stratifies risk, but is not an exhaustive list of medications implicated in prolongation of QTc interval:

| High risk (QTc prolonged by over 30 millisecs) | Some risk (QTc prolonged by approx 10millisecs) | Risk not categorised |
|---|---|---|
| Antiarrhythmics, class Ia (ajmaline, cibenzoline, disopyramide) | Amisulpride | Amifampirdine |
| Antiarrhythmics, class III (amiodarone, cibenzoline, sotalol) | Chlorpromazine | Asenapine |
| Artemisinin derivatives (artemisinin, artemether/lumefantrine | Citalopram | Atomoxetine |
| Haloperidol | Escitalopram | Clarithromycin |
| Pimozide | Levomepromazine | Erythromycin |
| | Methadone (in doses greater than 100 mg) | Lithium |
| | Moxifloxacin | Lofexidine |
| | Paliperidone | Olanzapine |
| | Ranolazine | Quetiapine |
| | Quinine | Risperidone |
| | Ritonavir-boosted saquinavir | Solifenacin |
| | Sildenafil | Tizanidine |
| | Tolterodine | Trazodone |
| | Tricyclics | Zuclopentixol |
| | Vardenafil | |

Stockleys Drug Interactions (accessed online via www.medicinescomplete.com on 31/10/2012)

## Linezolid update

To prevent hospital admission, linezolid may now be prescribed by GPs **on microbiology advice only,** for certain conditions (initial prescription limited to 5 days or less). This has been decided in order to make appropriate use of NHS resources, for those patients who would otherwise need an admission for intravenous therapy. The microbiology department at BSUH will be recommending this treatment and are happy to be contacted on (01273 696955 x4619) for further information.

**GP Tips –** Antibiotic Information Leaflet, approved by HPA and RCGP, is a useful tool for clinicians to use within consultations for respiratory tract infections, thereby helping to avoid any unnecessary antibiotic prescribing for self-limiting conditions. The leaflet explains decision pertaining to antibiotics use; natural timeframe for their diagnosed illness; self-help management; when to seek help and the need for safe antibiotic prescribing. For more information, visit: www.rcgp.org.uk/clinical-and-research/target-antibiotics-toolkit/patient-information-leaflets.aspx