NHS BLMK CCG
Milton Keynes
Pharmaceutical Advisers

April 2021

PRESCRIBING NEWS

CCG Prescribing Group
3rd March 2021

A virtual meeting was held to discuss several topics:

- The Prescribing Incentive Scheme 21-22 was finalised by the BLMK Prescribing Committee and has now been sent out to practices. Action planning meetings should be held before July and may be across the PCN as long as a GP and Practice Manager from each practice attends.
- The Group received an update on the Covid-19 vaccination programme and practices were congratulated by the HealthWatch representative on the amazing progress being made.
- The meeting Terms of Reference were updated to reflect the new organisational structure from 1st April. There will still be a local MK Prescribing Group.
- The GMC updated Good practice in prescribing and managing medicines and devices was noted – see more information later in the newsletter.

Milton Keynes Prescribing Advisory Group (MKPAG)
24th March 2021

A virtual meeting was held to discuss several topics:

- Two Glycopyrronium Bromide oral solutions were added to the formulary. The Generic 1 mg/5mL oral solution sugar free has been used but was never formally added to the formulary. In addition, a new branded product, Sialanar® 400 micrograms/mL oral solution, was added as a cost-effective choice for new patients. Patients should not be switched between the two products as their bioavailability is different.
- Novo Nordisk are phasing out Norditropin SimpleXx® during the year and replacing it with Norditropin FlexPro®. Therefore, the new product was added to the formulary.
- NICE TA 679 was noted. This approves the use of dapagliflozin in chronic heart failure with reduced ejection fraction. Please see later for more information.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website https://www.formularymk.nhs.uk/Default.asp

Update following the creation of BLMK CCG

Readers will be aware that Milton Keynes, Bedfordshire and Luton CCGs merged on April 1st to form the BLMK CCG. This has resulted in some changes to the organisational structures. However, whilst the three Medicines Optimisation Teams have formally merged into one, there remains a strong emphasis on place-based work. This means that the former MKCCG Pharmaceutical Adviser team will still be supporting practices in MK and working with the local providers and care homes. All our contact details remain the same.
The team is delighted to welcome Sarah Wocka who joins us as Paediatric Prescribing Team Dietitian, who is also working with the MK hospital Dietitian team.

The MK Prescribing Group will continue but the Milton Keynes Prescribing Advisory Group and the Bedfordshire and Luton Joint Prescribing Group will merge to form one Area Prescribing Committee so that the population of BLMK have access to the same treatment policies.

MHRA Safety Alerts

1. Pregabalin

The MHRA has issued a warning about risks of severe respiratory depression with Pregabalin.
Pregabalin (Lyrica): reports of severe respiratory depression - GOV.UK (www.gov.uk)

Pregabalin has been associated with infrequent reports of severe respiratory depression, including some cases without the presence of concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment; those using concomitant central nervous system (CNS) depressants; and people older than 65 years might be at higher risk of experiencing these events.

Prescribers are advised to consider whether adjustments in dose or dosing regimen are necessary for patients at higher risk of respiratory depression, this includes people:

- with compromised respiratory function, respiratory or neurological disease, or renal impairment
- taking other CNS depressants (including opioid-containing medicines)
- aged older than 65 years

Patients should be advised to avoid alcohol during treatment with pregabalin.

2. Ulipristal acetate 5mg (Esmya®)

Ulipristal acetate 5mg (Esmya): further restrictions due to risk of serious liver injury - GOV.UK (www.gov.uk)

Although the temporary suspension of the Esmya license has been withdrawn, its indication has been further restricted due to the risk of serious liver problems. It is only licensed for the intermittent treatment of moderate to severe symptoms of uterine fibroids before menopause and when surgical procedures are not suitable or have failed.

Prescribers are reminded that this product should only be prescribed in secondary care (Red message on OptimiseRx). Please check that you do not have any legacy patients with it still on repeat. Any patients should be reviewed for on-going need, the risks and benefits explained to them and liver function tests must be performed monthly during the first 2 treatment courses. For further treatment courses, liver function must be tested once before each new treatment course and when clinically indicated.

If a patient shows signs or symptoms compatible with liver injury (fatigue, asthenia, nausea, vomiting, right hypochondrial pain, anorexia, jaundice), treatment should be stopped, and the patient investigated immediately. Liver function tests should be performed urgently. Stop treatment if transaminase levels (ALT or AST) are greater than 3-times the ULN and closely monitor patients. The need for specialist hepatology referral should be considered.

Liver function tests should also be performed 2–4 weeks after treatment has stopped.

3. Alkindi® (hydrocortisone granules in capsules for opening)

Although this product is not on the MK Formulary, there is a possibility that patients may be started on it at tertiary centres. The company has issued an alert to warn prescribers that:

- Adrenal crisis has been reported in an infant who was switched from hydrocortisone soluble tablets to Alkindi (hydrocortisone granules in capsules for opening).
- Acute adrenal insufficiency could occur when switching to Alkindi granules due to a potential risk of inaccurate dosing possible with other oral hydrocortisone formulations, crushed or compounded.
- To prevent adrenal crisis after switching to Alkindi granules, carers should be advised to carefully observe the child during the first week for symptoms of adrenal insufficiency such as tiredness, headache, unstable temperature and vomiting.
- Carers should be advised to give extra doses of Alkindi granules as recommended in the product information, if the child develops symptoms of adrenal insufficiency and seek immediate medical attention.

Chloramphenicol Eye Drops 0.5%

Chloramphenicol eye drops are now contra-indicated in children under two by most manufacturers due to the presence of boron/borates in the formulation. This is not a new formulation or safety issue, so there is no related warning from the MHRA. It follows an update issued in 2017 to EMA mandatory labelling guidance on excipients. There is a 3-year timeline to implement these changes.

According to the EMA guidance, any product that would result in exposure to more than 1 mg daily of boron should be labelled as not to be used in children under 2 years. Chloramphenicol eye drops contain around 3 mg boron per ml, so when used correctly they are unlikely to result in this level of exposure; however, it seems that most companies have taken the precautionary route and removed from licence. For older patients, the limits for boron exposure are increased, and hence why this applies to less than 2 years old.

Chloramphenicol eye ointment

Chloramphenicol eye ointment is used in children of all ages, does not contain boron/borates, and therefore the new contraindication does not apply.

However, many of the chloramphenicol eye ointment preparations are pharmacy-only (“P”) medicines, and as such are licensed for use in children over the age of 2 years. This is not the same as a contraindication, and likely reflects the fact that it is advisable that antibiotic eye preparations be used in very young children only under the supervision of a prescriber.

Guidance

The BNF and BNF-C have not yet caught up with the changes, and neither has the NICE guidance on antimicrobial prescribing in primary care (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/antimicrobial-prescribing-guidelines). We are aware that the UK Ophthalmic Pharmacy Group and the Royal College of Ophthalmologists are likely to put out a statement on this topic, which should provide useful advice if this becomes available.

Options

The following options may be appropriate, depending on the clinical situation:

- **Symptomatic treatment**. Advise that most cases of bacterial conjunctivitis are self-limiting and resolve within 5–7 days without treatment.

- **Chloramphenicol eye ointment**. This is likely to be suitable for most patients. If a 'P' labelled chloramphenicol eye ointment is dispensed for a child aged under 2 years, the parents / carer should be counselled that although the PIL will state that it should not be used in a child of this age, it is acceptable under medical direction.
- **Fusidic acid eye drops**. Fusidic acid has a much narrower spectrum of activity compared to chloramphenicol, so if there is doubt over its suitability the local ophthalmology team may be able to advise. Neither contain boron/borates and both can be used from birth.

Medicines containing Peanut Oil / Arachis oil

Healthcare professionals are advised to consider the potential for allergic reactions to occur when prescribing or dispensing medicines to patients with a known peanut allergy.

Peanut oil (also known as arachis oil) is present in a number of medicines. The peanut oil used in medicines is highly refined and the majority, if not all, of the peanut protein is removed during manufacturing. However, as life-threatening allergic reactions can occur with minimal exposure to peanuts, caution is recommended with the use of medicines containing peanut / arachis oil in patients with a known peanut allergy. There is also a risk of cross-sensitivity with Soya Oil.

The following list is not exhaustive but gives some examples of medicines containing this oil: -

- **Abidec drops**
- **Adcal D3 chewable tablets**
- **Estriol cream**
- **Naspetin cream**
- **Isotretinoin capsules**
- **Peppermint oil capsules**
- **Salmeterol inhaler**
- **Sustanon injection**
- **Siopel barrier cream**
- **Utrogestan (progesterone) capsules**

The Read code for arachis oil allergy is Xa5pS. An OptimiseRx message is being developed to alert prescribers and recommend alternative products. We will also get a clinical report published in our MK medicines management folder to search for patients that may have the items on repeat and have the read code recorded.

Blood glucose testing in peritoneal dialysis patients

Patients who are also undergoing peritoneal dialysis and who need to test their blood glucose must use meters that are compatible with the extraneal (icodextrin) PD solution. These meters are not currently highlighted on the local guidance, but compatible ones include the formulary choices of GlucoRx Q, TEE 2 and Wave Sense Jazz or, alternatively use the meter advised by the specialist team.

Esomeprazole capsules vs tablets

Milton Keynes Hospital has recently been using **esomeprazole** tablets in preference to capsules. However, the tablets are more expensive in primary care and so you will be prompted with an OptimiseRx message to change to capsules if you try and prescribe tablets. Please do accept this suggestion and switch over to esomeprazole capsules.

New GMC Prescribing Guidance

The GMC has recently updated its **Good practice in prescribing and managing medicines and devices: updated guidance.** The full report **c**an be found at https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/Good-practice-in-prescribing-and-managing-medicines-and-devices-updated

In brief, the main changes from the previous version are: -

- new advice for doctors to stop prescribing controlled drugs without access to patient records, except in emergencies.
- stronger advice on information sharing, making it clear that if a patient refuses consent to share information with other health professionals it may be unsafe to prescribe.
- alignment with their updated 'Decision making and consent' guidance, highlighting the importance of good two-way dialogue between patients and doctors in all settings.
- updated advice on treating patients based overseas to clarify doctors may need to register in the country where they are based, where the patient is based, and where prescribed medicines are to be dispensed.

A reminder about Amiodarone

The NICE Clinical Guideline on Atrial Fibrillation: Management (CG180) states that amiodarone **should not be used long term for rate control** in atrial fibrillation (AF) and that where used for rhythm control before or after electrical cardioversion it should only be for up to 12 months.

As Amiodarone has potential major toxicity and requires monitoring both clinically and via laboratory testing, it should only be prescribed long-term where other treatments cannot be used or have failed. These patients should be under the supervision of Cardiology.

The BNF lists toxicities as:

- **Corneal micro-deposits** Patients taking amiodarone may develop corneal micro-deposits (reversible on withdrawal of treatment). However, if vision is impaired or if optic neuritis or optic neuropathy occur, amiodarone must be stopped to prevent blindness and expert advice sought.
- **Thyroid function** Amiodarone contains iodine and can cause disorders of thyroid function; both hypothyroidism and hyperthyroidism can occur. Hypothyroidism can be treated with replacement therapy without withdrawing amiodarone if it is essential; careful supervision is required.
- **Hepatotoxicity** Amiodarone is also associated with hepatotoxicity and treatment should be discontinued if severe liver function abnormalities or clinical signs of liver disease develop.
- **Pulmonary toxicity** Pneumonitis should always be suspected if new or progressive shortness of breath or cough develops in a patient taking amiodarone.

Arrangements are being put in place for patients on long term amiodarone to be reviewed.

NICE TA 679 Dapagliflozin in chronic heart failure with reduced ejection fraction

Dapagliflozin has been approved by NICE as an option for treating symptomatic chronic heart failure with reduced ejection fraction in adults, only if it is used as an add-on to optimised standard care with:

- angiotensin-converting enzyme (ACE) inhibitors or angiotensin-2 receptor blockers (ARBs), with beta blockers, and, if tolerated, mineralocorticoid receptor antagonists (MRAs), or
- sacubitril / valsartan, with beta blockers, and, if tolerated, MRAs.

Treatment with dapagliflozin should be started for symptomatic heart failure with reduced ejection fraction on the advice of a heart failure specialist.

A clinical trial compared dapagliflozin as an add-on treatment to standard care (based on an ACE inhibitor, ARB or sacubitril / valsartan) with standard care alone. Evidence from the trial shows that dapagliflozin lowers the risk of dying from cardiovascular causes and reduces the likelihood of hospitalisation or an urgent outpatient visit because of heart failure.

There are no trials directly comparing dapagliflozin with sacubitril / valsartan. An indirect comparison shows dapagliflozin is likely to be as effective at reducing the risk of death from cardiovascular causes.

Learning from incidents

Recently a patient was mistakenly discharged from hospital on **quetiapine** instead of **quinine**. The medicine was incorrectly noted as “continuation” on the discharge summary and the error was continued in primary care until the patient’s usual doctor came back from leave and queried with the hospital why quetiapine had been started.

> If a medicine that has not previously been prescribed for the patient in primary care appears on their discharge letter as continuation it should be checked in case it is an error – especially if the medicine does not appear to relate to the patient’s clinical condition whilst they were in hospital. Please use the Medicines recommended by Milton Keynes University Hospital Specialists Clarification of a recommendation or Decision to decline prescribing form on SystmOne.

Prescribing Cascade: Calcium channel blockers and diuretics

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2761272

A prescribing cascade occurs when an adverse drug event occurs that is misinterpreted as a new medical condition resulting in the initiation of another drug to treat it. Prescribing cascades are recognised as an important contributor to problematic polypharmacy.

A recent JAMA article has highlighted a common prescribing cascade where older people who have recently been prescribed a calcium channel blocker (CCB) were subsequently given a loop diuretic, which may have been unnecessary. The authors recommend that if a patient on a CCB develops peripheral oedema, even if it occurs weeks to months after the start of CCB treatment, clinicians should consider whether the CCB is still necessary, whether it could be discontinued or the dosage could be reduced, or whether the patient can be switched to another therapy. Non-pharmacologic strategies to address peripheral oedema should also be considered.

Antiplatelet Therapies

We are seeing the combination of dual antiplatelet therapy (DAPT) with an anticoagulant for triple therapy more frequently now on hospital discharge summaries from cardiology. Although this may become more familiar, the triple therapy will be for a short period, usually a month, with the continuation of dual therapy for a further 11 months before one of the medications continues for life. These instructions should be reflected on the discharge summary and then captured on SystmOne. (see Supplement August 2020 edition for tips on this) If there are no clear time periods on the discharge summary then please raise this with the hospital pharmacy department for clarity using the template letter on SystmOne, do not assume all 3 medications are to continue for 12 months.

Patients under several specialists can be on antiplatelet combinations for different conditions. This is not always considered by the relevant teams and can be a potential for confusion if there is information advising for one to stop that is being used as treatment for a different condition. So please get clarity that this is the intention and all the patient's conditions are being considered.

Patients on DAPT are not always started on gastroprotection at discharge which has been flagged with secondary care. There are messages to prompt this on OptimiseRx as needed. Lansoprazole is the preferred choice when co-prescribed with clopidogrel.

Double Red Medicines

It is apparent from OptimiseRx data that 2 surgeries have prescribed Thuasne Action Reliever knee braces even though the prescribers will have been presented with a Double Red message indicating that the knee braces should not be prescribed. Disregarding these messages leads to inequity as many prescribers do take note of them and also causes problems if patients move to another practice.

There has been a recent similar issue with prescriptions for Dapoxetine which has not been approved for the formulary across BLMK.

Please follow the guidance in the Orx message and if you disagree with it, please get in touch with your CCG Pharmacist for advice first rather than overriding the message and prescribing.

More about the 21-22 Prescribing Incentive Scheme

Practices have recently received details of the 2021-22 Prescribing Incentive Scheme. This is a quality driven scheme with elements to encourage cross-PCN working and sharing.

Targets include

- Qualifying target: meet your CCG pharmacist to discuss the targets (this can be across PCN) and produce an action plan to deliver targets
- Mandatory target: Antimicrobial prescribing – all practices will be monitored against volume and 3Cs. There is also a UTI review

Optional targets:

- Opioids including encouraging patients to step down from high dose opioids, reduction in volume, attendance at training session
- Self-care: Reduce prescribing, work across PCN for consistent messaging and promote use of Community Pharmacy Consultation Scheme
- Respiratory: ICS, SABAs, Spacers, Asthma action plans
- DOACs: Reviews to ensure safe management
- Drug monitoring process: Practice process and policy to identify patients on high risk medicines; share work across PCN, searches to ensure patients are being recalled appropriately

Please note that, unlike previous years, it is not necessary to reach a certain number of points before the practice receives payment. You may choose to work on all or just some of the targets and will be paid for each target that is completed successfully. Completing all the targets will provide a similar level of income as achieving £1 per patient in the old scheme. Templates and searches will be coming out to practices soon.

The Pharmaceutical Advisers can be contacted on 01908 278744 or 278713 or speak to your CCG practice pharmacist