Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

December 2020

CCG Prescribing Group 4th November 2020

A virtual meeting was held to discuss several topics:

- Dr Tamara Baros was welcomed as a new GP on the group.
- Prescribing Incentive Scheme results for the 2019/20 were approved. Congratulations to the practices.
- Possible targets for the 2021/22 Prescribing Incentive Scheme were discussed. The scheme will be across BLMK practices but will build on some of the targets that have been in the MK scheme.
- There will be a BLMK-wide Primary Care Prescribing Group as well as our local group. Dr Nigel Fagan is the MK GP representative on the new group.

Milton Keynes Prescribing Advisory Group (MKPAG) 25th November 2020

A virtual meeting was held, and the following decisions were made:

- The BLMK Paediatric Asthma and childhood wheeze Guidelines were approved and can be found on the formulary website.
- Bempedoic acid for lipid management was approved for **hospital only** prescribing and is designated as Red on OptimiseRx pending NICE Guidance. Statin intolerance was discussed as part of this item –please see later.
- Freestyle Libre is now available for people with Type 1 diabetes or type 2 on insulin who are on the Learning Disability Register.
- Abbott have introduced new Freestyle Libre 2.0 sensors which are being phased in (patients will be started on / switched to by IDIS). Please take care when prescribing to select the correct sensor for the patient's device.

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

MHRA Safety Alerts

1. Yellow Card reporting

The MHRA is keen to remind healthcare professionals and patients to report suspected adverse reactions to medicines via the yellow card reporting system https://yellowcard.mhra.gov.uk
Reporting helps to identify new adverse drug reactions, recognise unexpected and serious safety problems, and gain more information about known effects. The scheme extends to cover incidents involving medical devices (and via the app), defective, fake medical products and safety concerns for e-cigarettes or their refill containers (e-liquids).

2. Warfarin and other anticoagulants: monitoring of patients during the COVID-19 pandemic

Following concerns raised by clinicians during the coronavirus (COVID-19) pandemic, The MHRA has issued guidance regarding the safe use of warfarin and other anticoagulants. This advice has been endorsed by the Commission on Human Medicines (CHM).
https://www.gov.uk/drug-safety-update/warfarin-and-other-anticoagulants-monitoring-of-patients-during-the-covid-19-pandemic

Healthcare professionals are reminded that:

- acute illness may exaggerate the effect of warfarin and necessitate a dose reduction; patients on warfarin or other vitamin K antagonists should therefore be asked to tell their GP or healthcare team if they have symptoms of, or confirmed, COVID-19 infection
- continued INR monitoring is important in patients taking warfarin or other vitamin K antagonists if they have suspected or confirmed COVID-19 infection, so they can be clinically managed at an early stage to reduce the risk of bleeding
- both vitamin K antagonists and direct-acting oral anticoagulants (DOACs) may interact with other medicines and if a patient using these oral anticoagulants is also prescribed antibiotics or antivirals, follow advice in the product information for minimisation of risk of potential interactions – this includes INR monitoring in patients taking vitamin K antagonists who have recently started new medicines
- if patients are switched from warfarin to a DOAC, warfarin treatment should be stopped before the DOACs is started to reduce the risk of over-anticoagulation and bleeding. Please ensure warfarin is stopped on repeat.
- patients taking vitamin K antagonists should be reminded to carefully follow the instructions for use for anticoagulant medicines (including the patient information leaflet) and to tell their GP or healthcare team if they:
  - are otherwise unwell with sickness or diarrhoea or have lost their appetite
  - are taking any new medicines or supplements
  - have changed their diet, smoking habits, or alcohol consumption
  - are unable to attend their next scheduled blood test for any reason, including because they feel unwell.

Prescribing Safely – some reminders

Amlodipine and simvastatin

If a patient is on amlodipine 5mg or above the maximum dose of simvastatin should be 20mg or use atorvastatin instead. There is an ORx message for this which in Aug-Oct 2020 had a hit count of 50 but only 10% acceptance when simvastatin 40mg was prescribed with amlodipine. This indicates that patients are still on the incorrect doses and should be reviewed.

Clopidogrel and PPIs

If a patient is on clopidogrel and a PPI is required the best choice is to use lansoprazole as esomeprazole or omeprazole can reduce the efficacy of the clopidogrel. This is highlighted with 3 red stars in the drug and appliance browser on S1 when co-prescribed.

Colchicine

Colchicine prescriptions – ePACT data shows that some large quantities of colchicine are being prescribed for gout. As a reminder, no more than 6 mg (12 tablets) should be taken as a course of treatment.

'When required' doses for CDs – clear dosing instructions

NICE NG46 Controlled drugs safe use and management recommends, when prescribing 'when required' controlled drugs to:

• *Document clear instructions for when and how to take or use the drug in the person's care record*
• *Include dosage instructions on the prescription (with the maximum daily amount or frequency of doses) so that this can be included on the label when dispensed*
• *Ask about and take into account any existing supplies the person has of 'when required' controlled drugs.*

https://www.nice.org.uk/guidance/ng46

Including clear dosage instructions is particularly important when prescribing for breakthrough pain where the usual dose is one-tenth to one-sixth of the regular 24-hour dose every 2-4 hours. If the maximum number of rescue doses taken in a day are not specified the patient could inadvertently double or quadruple their daily dose with potentially fatal consequences. (The BNF states that pain management should be reviewed if rescue doses are required twice daily or more). https://bnf.nice.org.uk/guidance/prescribing-in-palliative-care.html

Whenever prescribing 'when required', 'as necessary' or 'as needed' for any drug consider adding the reason a dose would be required, for example:

- 'only if pain is severe' for breakthrough pain or chronic pain
- 'for occasional sleeplessness, do not take every day' for drugs for insomnia

Anyone dispensing a prescription for a CD should ensure that both the individual unit dose and the maximum total daily dose is clear from the directions on the label.

Prevention of Future Deaths—Regulation 28 letter issued the coroner

Regulation 28 letters allow the coroner to highlight concerns to do with the case that, in their view, require action in order to prevent future deaths.

Earlier this year a patient living in the East on England died of a tramadol overdose. The full report and response are available at https://www.judiciary.uk/publications/peter-cole/

The patient had a diagnosis of dementia. He was in receipt of a large number of drugs on repeat prescription, one of which was tramadol. He was prescribed 100 Tramadol per month over a long period of time and had amassed a large quantity at his home. During the inquest an experienced mental health nurse told the coroner this was far from unusual, particularly for older patients with varying degrees of mental impairment.

The Matters of concern raised by the coroner were as follows:

• That repeat medication is not being adequately monitored, leading to many (often older and/or mentally infirm) patients building up dangerous quantities of prescribed medication.
• That inadequate supervision of prescribed (repeat) medication is so widespread that the consequent waste of resources has an adverse impact on the overall provision of healthcare.

The coroner's letter did not indicate whether the overdose was accidental or intentional, but the matters of concerns are points well made. The response made by NHS England and NHS Improvement mentioned various ways in which these concerns are being addressed. Other practical solutions have already been implemented in small areas within East of England but are worth consideration to spread more widely:

- ✓ Nurses and other healthcare staff making domiciliary visits to patients have a referral pathway back to the prescriber when large quantities of medicines are observed.
- ✓ Community pharmacies can be commissioned to provide a domiciliary review service, checking on medicines in the patient's home.

Statin Intolerance

As we know, statins are the cornerstone for prevention and treatment of cardiovascular disease with a substantial evidence of reduction of morbidity and mortality. In clinical trials, statins were found to be largely well tolerated (often with a similar adverse effect profile to placebo), however this is not reflected in clinical practice where up to 75% of people started on a statin will discontinue treatment within 2 years.

Statin-associated muscle symptoms (SAMS) are one of the principal reasons for statin non-adherence and/or discontinuation. However, not all such symptoms should lead to a label of 'statin intolerance' as they may not be truly statin related muscle toxicity (SRM) as demonstrated by resolution on de-challenge and recurrence with re-challenge. There is a risk patient may be labelled as 'statin intolerant' too quickly and therefore do not benefit from them or have treatment changed to other medicines. Stopping statin therapy is associated with an increased risk of major CV events

NHS England and the Accelerated Access Collaborative have produced a Pathway for the management of Statin Intolerance for patients with CVD risk that has been endorsed by NICE.
statin-intolerance-pathway-03092020.pdf (england.nhs.uk)

Statin intolerance is defined as the presence of clinically significant adverse effects that represent an unacceptable risk to the patient or that may reduce compliance with therapy. Another definition is any adverse event considered unacceptable by the patient, and/or some laboratory abnormalities, both attributed to statin treatment and leading to its discontinuation.

Considerations when starting a statin to reduce risk of SRM include

- Check baseline thyroid, liver and renal function, any potential drug interactions, and avoid the highest doses in at risk groups (See "Risk Factors" below).
- Ask the person if they have had persistent generalised unexplained muscle pain, whether associated or not with previous lipid-lowering therapy. If they have, measure CK. If CK levels are > 4x ULN do not start statin - investigation required. Do not measure CK if person is asymptomatic. •
- Warn patients about AEs, specifically muscle symptoms. Advise people who are being treated with a statin to seek medical advice if they develop muscle symptoms (pain, tenderness or weakness). If this occurs, measure CK.

Risk factors include:
Female gender, advanced age (> 75 years), frailty (reduced lean body mass), history of muscle disorder or high CK, impaired renal or hepatic function, personal or family history of intolerance to lipid-lowering therapies, hypothyroidism
Exogenous risk factors include excessive alcohol intake, high intensity exercise, dehydration, drug interactions with statins (including herbal medicines), vitamin D deficiency.

It is important to note that statins receive a lot of bad press so the patient may be reluctant to start them despite their proven benefits.

Statin based approaches to managing muscles symptoms include:

- Therapy with a lower dose statin is preferred to no statin
- Apply a repetitive "De-Challenge" - "Re-Challenge" approach to establish if symptoms are caused by a statin(s) and the best statin regimen for each patient.
- Switch to a different statin by their lipophilicity as patients that do not tolerate simvastatin or atorvastatin can sometimes be alright with pravastatin or low dose rosuvastatin. Start with a low dose and titrate up. It is always worth trying before abandoning statins. (Ref BMJ BMJ 2008; 337:a2286)
- Re-challenge with the same statin using a lower dose or frequency (intermittent dosages). For patients who do not tolerate statins on a daily basis, alternate day or twice-weekly dosing is a good option. Rosuvastatin and atorvastatin have longer half-lives, permitting their use on a non-daily regime.
- Adding ezetimibe to a lower dose statin may be better tolerated with better reduction of LDL-C / non-HDL-C.
- Once a new regime is tolerated, dose / frequency can be up-titrated slowly to achieve LDL-C / non-HDL-C goals with minimal or no muscle complaints. It is important to note that cardiovascular benefits have not been proven for all the above approaches but any reduction of LDL-C / non-HDL-C is beneficial.

One off nominations for Appliance Contractors

A change has recently been made by NHS Digital so the appliance contractors listed below can now be selected as a one-off nomination:

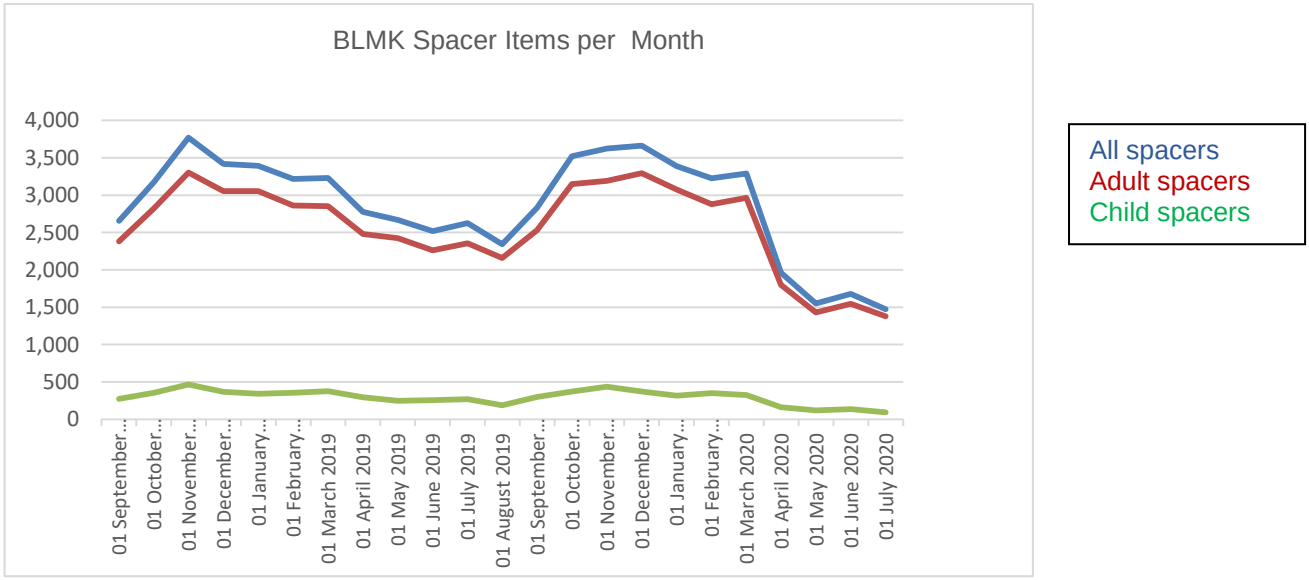
- Homeward Pharmacy (FL377)
- Calea UK Limited (FVG64)
- H2H Pharmacy Ltd (FWN00)

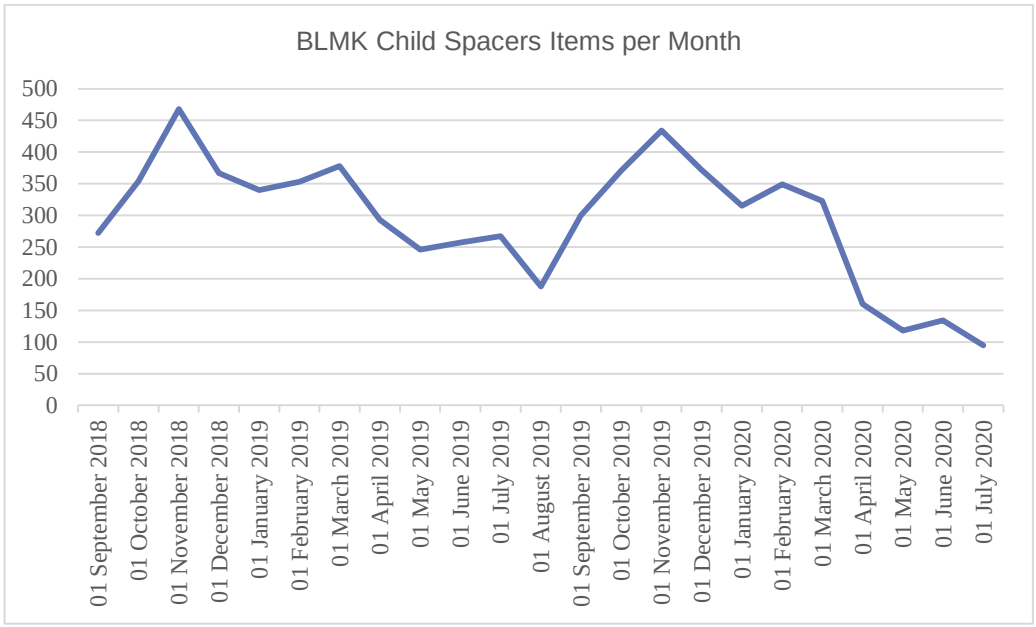
To search for any of the above, the postcode the users will need to use is ZE1 0AA (dummy postcode)

Spacer prescribing has declined

There has been a decrease in prescriptions for spacer devices this year. The decrease in the number of prescriptions in April and May is understandable as reviews were cancelled. However, since consultation numbers have risen, the spacer levels have actually decreased even further.

It's a concern to see MDI prescriptions back to 'normal' levels when spacer prescriptions have dropped to roughly 50% of where they should be. This could mean that patients if they are not receiving their new spacer prescription at review or being provided with a spacer on initiation of a metered dose inhaler. Face to face reviews may not effectively check the patient's inhaler technique or prompt replacement of old spacers.





The BTS Asthma Guidance recommends that spacers should be replaced at least every 12 months. Please bear this in mind when reviewing patients.

Denosumab stop dates

Patients should not stop denosumab without specialist review as there is an increased risk of multiple vertebral fractures after stopping denosumab for osteoporosis. Please ensure that prescriptions do not have a stop date to prevent it being stopped without review. The optimal duration of denosumab treatment for osteoporosis has not been established; the need for continued treatment should be re-evaluated periodically based on the expected benefits and potential risks of denosumab on an individual patient basis, particularly after 5 or more years of use.

Practices should have a system for recalling patients within the timeframe (the injections must be given every 6 months plus or minus no more than 2 weeks. Blood tests are needed before each injection to check serum adjusted calcium and vitamin D are normal and eGFR is > 30 ml/min within the 4 weeks before each injection.

Reminder for practices to buy in Denosumab and claim back via FP34PD (Peach) form as Personally Administered.

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