LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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In this issue …

Antiviral drugs for prophylaxis and treatment of influenza

The editorial team are aware there may be confusion amongst clinicians about the use of antiviral drugs for influenza. This article provides a summary of the information available.

The vast majority of clinical trials involving antiviral drugs in the prevention and treatment of influenza have been in healthy adults with few studies in children or in high-risk groups. The effect of oseltamivir or zanamivir on hospitalisation or on mortality is not clear in those at risk of serious complications from influenza. In otherwise healthy individuals, oseltamivir and zanamivir reduce the duration of symptoms of influenza by about 1 to 1½ days.

The National Institute of Clinical Excellence (NICE) has produced guidance[1,2] on the use of antiviral drugs for people in high risk groups when influenza is circulating in the community. This has been endorsed by NHS Quality Improvement Scotland. The Scottish Centre for Infection and Environmental Health (SCIEH; www.show.scot.nhs.uk/scieh) has reported rising levels of influenza in Scotland[3].

This table illustrates when it is possible to prescribe antiviral drugs for the prophylaxis and treatment of influenza in at-risk* groups when influenza A or influenza B is circulating in the community

Antiviral drug	Prophylaxis	Treatment
oseltamivir (Tamiflu®)	√ aged 13 years & over and who have not been vaccinated and who have been exposed to someone with ILI† within the last 48 hours	√ aged 1 year & over within 48 hours of the first symptoms
zanamivir (Relenza®)	X not licensed	√ aged 13 years & over within 48 hours of the first symptoms

* at-risk groups: those aged over 65 years or those who are in at least one of the following groups: have chronic respiratory disease (including chronic obstructive pulmonary disease and asthma); have significant cardiovascular disease (excluding hypertension); have chronic renal disease; are immunocompromised; have diabetes mellitus; Royal Hospital for Sick Children guidance also includes chronic respiratory disease associated with neurological problems and prematurity

† NICE define exposure to influenza like illness (ILI) as being in close contact with someone who lives in the same home environment as a person who has been suffering from symptoms of ILI

Key messages:

- **These drugs are not a substitute for vaccination.**
- **Antiviral drugs for the prophylaxis and treatment of influenza should only be prescribed for patients in the at-risk groups.**
- **These drugs are not recommended for use in otherwise healthy individuals.**

References:

1. Guidance No. 58: www.nice.org.uk/pdf/58_Flu_fullguidance.pdf
2. Guidance No. 67 www.nice.org.uk/pdf/67_Flu_prophylaxis_guidance.pdf
3. Influenza notice. Scottish Executive Health Department. Letter. 5 November 2003. www.show.scot.nhs.uk/sehd/publications/DC20031105influenza.pdf

Contact the editorial team at ljf@lhb.scot.nhs.uk

New year resolution - no more drinking

Jonathan Chick, Consultant Psychiatrist, Alcohol Problems Service, LPCT writes…

I'm not sure about all these benzodiazepines for alcoholics

Since cessation of drinking is unlikely to be complicated in mild dependence I was pleased to see in a recent referral letter, that a GP specifically stated that he had not prescribed the benzodiazepine requested by the patient.

Medication to prevent serious withdrawal reactions, and/or to alleviate severe craving, is not normally necessary if:

- the patient reports consumption of less than 15 units/day (men) or 10 units/day (women) and reports neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- at examination, the patient has no alcohol on the breath, and shows no withdrawal signs.

When medication to manage withdrawal is not indicated, patients should be informed that at the start of detoxification they may feel nervous or anxious for several days, with difficulty in going to sleep for several nights. Among periodic drinkers, whose last bout was less than one week long, medication is seldom necessary unless drinking was extremely heavy (over 20 units/day).

The SIGN Guideline 'The Management of Harmful Drinking and Alcohol Dependence in Primary Care' recommends that where medication for detoxification in the community is offered, it should be delivered using protocols specifying daily monitoring of breath alcohol level and withdrawal symptoms, and dosage adjustment. It recommended that every GP practice (and out-of-hours service) would benefit from access to a breathalyser. If you are interested in this, more information is available on the SIGN website (www.sign.ac.uk).

Lothian, rural areas included, now has 10 community nurses specialised in alcohol problems. Ideally community detoxification commenced by the GP would be monitored using a breathalyser. Sadly, Lothian's Alcohol CPNs are sorely stretched - according to hospital admission rates and alcoholic liver disease mortality data we have an epidemic of alcoholism in the UK today.

There are risks in too ready and repeated offers of medication for detoxification. Switching from alcohol to benzodiazepine to alcohol intensifies the patient's dependence. There is research hinting that frequent detoxification may speed up brain impairment and emergence of epilepsy.

Detoxification should be seen as an elective procedure, to be conducted when a strategy for sustaining abstinence is in place. The only exceptions, for which urgent treatment is needed, are when pressing medical or psychiatric complications are present. The classic case, avoidable by prophylactic benzodiazepine, is the newly admitted general hospital patient who becomes delirious during the night.

Intoxicated patients presenting to the GP, out-of-hours services or A&E, requesting detoxification, should be advised to make a primary care morning appointment and be given written information about community agencies so that they can plan how to sustain their abstinence after detoxification, since the goal of detoxification is abstinence.

Patients discharged from hospital before the final day of their reducing regimen may be issued the remaining supply as discharge medication, with a reducing dosage specified and advice not to take alcohol, drive a car or operate machinery.

The Lothian guideline for the management of individuals with alcohol related problems (January 1997) is currently under review.

We would like to thank Dr Chick for writing this article.

Key messages:

- **Medication is not indicated for mild withdrawal from alcohol.**
- **Medication is not normally necessary if the patient reports consumption of less than 15 units/day (men) or 10 units/day (women).**
- **Repeated detoxification prescriptions might be harmful in some patients.**
- **Detoxification is best conducted electively when strategies for subsequent complete abstinence are in place.**

New year resolution - no more smoking

LJF update on smoking cessation

Stopping smoking at any age has major health benefits. New guidelines, which will shortly be available, from NHS Health Scotland and ASH Scotland state that all smokers making an attempt to stop should have ready access to, and be strongly encouraged to use, dedicated Smoking Cessation Services (SCSs) involving structured behavioural support and NRT or bupropion[1]. Behavioural support should involve a structured protocol to ensure that all aspects of motivational and medication advice are delivered.

Lothian Joint Formulary section 4.10(h):

Step 1:	smoking cessation support based on assessment of patient's motivation to quit
Step 2:	**nicotine replacement therapy (NRT):** **First choice: nicotine patch** + cessation support **Second choice: nicotine oral preparation** + cessation support
Step 3:	**bupropion** + cessation support

The Prescribing notes include key changes such as repeat courses of NRT and prescribing for pregnant women and adolescents.

- Prescribing of NRT or bupropion should not commence until the patient has decided on a 'target stop date'. Initial prescriptions should be sufficient to last until 2 weeks after this date (usually after 2 weeks of NRT and 3-4 weeks of bupropion). Further prescriptions should only be issued if attempts to quit are continuing at review. NRT or bupropion must not be added to repeat prescribing systems.
- Repeat courses should not normally be initiated within 6 months if attempt to quit is unsuccessful, except in exceptional circumstances.
- Prescriptions for NRT should be for 1 month, endorsed 'dispense weekly'. There is little direct evidence that one nicotine product is more effective than another and choice is therefore guided by individual preference.
- NRT may be prescribed for pregnant women in whom non-pharmacological interventions have failed. Intermittent dose regimens are preferred to minimise foetal exposure to nicotine.
- NRT may be prescribed to adolescents on the advice of a relevant health care professional and with provision of significant support.
- There is currently insufficient evidence to recommend the use of an NRT preparation and bupropion in combination.

Smoking Cessation Services in Lothian

Smoking cessation support in Lothian is generally provided on a locality basis. Contact Fiona Moore or Jane Riddell, Smoking Cessation Co-ordinators, Deaconess House 0131 536 9414/5 or Helena Connelly, Smoking Cessation Clinical Nurse Specialist, West Lothian 01506 419666 ext 3000.

References:

1. West R, McNeill A, Raw M. Smoking Cessation Guidelines for Scotland, Consultation Document. NHS Health Scotland/ASH Scotland. September 2003

We would like to thank Helena Connelly and Lorna Wilkinson for their contribution to this article.

Competition!

Win a hand held computer…

We are pleased to announce a fantastic competition! The winning prize will be a hand held computer worth £300. Simply answer the questions on the enclosed form and complete the phrase using no more than 30 words. The competition is open to all recipients of the Lothian Prescribing Bulletin working in Lothian. The judges' decision will be final. Please send your answers to MMT no later than **29 February 2004.**

Bicalutamide 150mg (Casodex®): no longer indicated for treatment of localised prostate cancer

Following new clinical trial data, the Committee on Safety of Medicines (CSM) has recently advised that 150mg strength of bicalutamide is no longer licensed for the treatment of localised prostate cancer. A letter with more information has recently been distributed to all relevant health professionals[1].

Key message:

- **Review all patients receiving bicalutamide 150mg for localised prostate cancer.**

Reference:

1. Committee on Safety of Medicines (CSM) advice. Casodex 150 mg (bicalutamide): no longer indicated for treatment of localised prostrate cancer. 28 October 2003. (www.medicines.mhra.gov.uk/aboutagency/regframework/csm/csmhome.htm)

Emergency hormonal contraception - new dose instructions

Levonelle® can now be given as a single dose, the two 0.75mg levonorgestrel tablets can be taken together.

Although women can be recommended to use this new regimen now, confusion may arise as current packs will contain Patient Information Leaflets (PILs) with the old regimen. Packs will contain the new PILs from January 2004. Where appropriate, GPs, nurses and pharmacists should take the opportunity to explain the discrepancy between advice and the PIL.

Patient Group Directions (PGDs) for these products have been amended accordingly.

GPs should prescribe Levonelle-2® and not Levonelle® as Levonelle® is significantly more expensive.

Key messages:

- **Women can be advised to take two tablets together of Levonelle® or Levonelle-2®.**
- **GPs are reminded to prescribe Levonelle-2®.**
- **Levonelle® is available over the counter.**

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