LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 7

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In this issue ...

New arrangements in Lothian for the treatment of patients with dementia

There are now new arrangements for the treatment of patients suffering with dementia in Lothian. All GPs and specialists involved in the care of these patients have recently been sent a letter with details of the new system. The specialist group involved in the development of this new system has produced a care pathway to guide clinicians in the diagnosis and treatment of these patients. Further work is ongoing to develop protocols and structures to support the use of drug treatment for patients suffering with dementia based on best evidence.

All patients established on, and responding to anticholinesterase drug treatment for dementia, for 6 months or more will be transferred to GP prescribing under shared care protocol (SCP) arrangements.

SCPs for rivastigmine, galantamine and donepezil have been developed to support this transfer of prescribing to primary care. (Copies of the SCPs can be obtained from the Prescribing & Drugs Info' section in the primary care electronic library, http://lpctweb/elib/2_ClinicalPractice/home_cp.htm)

We wish to remind clinicians that memantine has not been recommended for use in Scotland by the Scottish Medicines Consortium (SMC). New drugs for the treatment of dementia should not be prescribed until they have been assessed by the SMC and their place in the Lothian Joint Formulary has been established.

A policy has been developed to enable the use of hospital based prescriptions (HBPs - known as blue prescriptions) by specialists in outpatient clinics to promote consistency across the Trusts. Specialists have been supplied with HBPs to enable prescribing for patients whilst under their supervision.

Key messages:

- **All patients with suspected dementia should be referred to their local sector old age psychiatrists.**
- **Drug treatment should only be initiated under the supervision of a specialist in old age psychiatry or a specified consultant in Care of Elderly Medicine. Prescribing should only be transferred to GPs following a satisfactory response to treatment after 6 months.**
- **A specialist clinic, based in Edinburgh, will provide a more detailed diagnostic service for complex patients (e.g. those with learning difficulties) in Lothian. This clinic will only accept referrals from specialists.**

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

Domiciliary Oxygen Therapy Services (DOTS)

The Minister for Health and Community Care recently announced changes in the arrangements for domiciliary oxygen therapy services (DOTS), which will apply as of 1 April 2004[1].

- From 1 April 2004, portable oxygen cylinders (460 litres) will be available on GP prescription. Currently, patients receive their oxygen either by prescription of large non-portable cylinders dispensed by community pharmacists, or by concentrators supplied through the hospital service on the recommendation of an appropriate consultant.

- The current threshold level of cylinder usage which triggers provision of an oxygen concentrator is 15 hours per day. The threshold is now reduced to 8 hours per day. Patients who are using oxygen for between 8 and 15 hours per day (more than 22 x 1360 litre cylinders over a 4 week period) should be referred to a respiratory consultant to decide whether a concentrator should be provided.

- Oxygen is expensive. For example, a patient using only one hour of oxygen per day from a cylinder costs £520 per annum, in comparison to an oxygen concentrator which costs approximately £720 per patient per annum and will provide unlimited oxygen.

- GPs should be aware that the prescription of portable oxygen cylinders is intended as an additional aid to facilitate social activities and is not intended to replace the existing large cylinders. The assessment as to whether a patient is suitable for portable oxygen cylinders must be made by a hospital consultant.

Ambulatory oxygen is indicated for patients with the following conditions:

- Chronic obstructive airways disease (COPD), interstitial lung disease, cystic fibrosis, neuromuscular/skeletal disorders requiring longterm oxygen therapy (LTOT), and who are mobile and able to leave home.
- Chronic hypoxaemia, using LTOT, and demonstrate improved exercise tolerance with ambulatory oxygen.
- COPD, interstitial lung disease, lung or other malignancy with an improvement of at least 10% in walking distance and/or breathlessness when walking with supplementary oxygen.

Key messages:

- **Review patients on repeat prescriptions for oxygen.**
- **Refer patients using more than 22 cylinders per month to a respiratory physician for consideration of an oxygen concentrator.**
- **For those patients using less than 22 cylinders per month, review the appropriateness of oxygen therapy.**
- **Consider referring any patients that may benefit from ambulatory oxygen.**
- **Oxygen is an expensive therapy, patients should be monitored to ensure it is being used appropriately.**
- **Ambulatory oxygen is not recommended in chronic heart failure.**

Reference:

1. Scottish Executive Health Department HDL(2004)1. Developments in the Provision of Domiciliary Oxygen Therapy Service (DOTS). 12 January 2004.
2. Scottish Executive Health Department HDL(2004)1 Addendum. Developments in the Provision of Domiciliary Oxygen Therapy Service (DOTS). 9 February 2004

Feedback to GPs on Lothian Joint Formulary adherence

Lothian Joint Formulary (LJF) Adherence Reports for the period July to September 2003 were circulated in February 2004 to all general practices in Lothian Primary Care NHS Trust and West Lothian Healthcare NHS Trust.

The reports aim to inform prescribers, promote the formulary and encourage consistent prescribing across primary and secondary care. The reports provide details of practice prescribing in relation to LJF recommendations for a range of drugs. These drug groups were selected following recommendations from the Primary Care Pharmacists and the LJF Implementation Working Group.

The drugs targeted in the report are:

- Isosorbide mononitrate
- Angiotensin-converting enzyme inhibitors
- Antihistamines
- Antidepressants
- Analgesics
- Oral non-steroidal anti-inflammatory drugs

Monitoring adherence to the LJF has been identified as one of the key objectives in the LJF Implementation Action Plan. This is an essential part of the overall strategy to encourage ongoing use of the formulary.

There are plans to produce secondary care reports to mirror those in primary care.

Something for nothing?

Guidance on the use of medication samples in hospitals

Medication samples should not be left in clinical areas nor should they be provided directly to patients.

Pharmacy departments support the safe and effective use of medicines and minimise the risk to patients. In the event of a medication product recall the pharmacy distribution audit trail is the only system that will guarantee any defective products are withdrawn from use within the specified time frame.

Control of procurement and distribution of medicines is the responsibility of the pharmacy department. A sample should only be accepted following agreement between the Chief Pharmacist and the prescriber.

The NHS Lothian University Hospitals' Division (LUHD) 'Policies and Procedures for Medicines' states that "staff in wards or other clinical areas must not accept medicine samples, including dressings, directly from a company medical representative".

If agreement is reached, the sample should be delivered directly to the pharmacy department with written authorisation stating the following:

1. Name of the doctor who will be prescribing the medicine.
2. The clinical area where it is to be used.
3. Quantity to be delivered.

Key messages:

- **Medication samples should not normally be used.**
- **In hospitals the procurement and distribution of any medication is the responsibility of the pharmacy department.**
- **All samples must have a robust audit trail.**

Further Reading:

1. Moynihan R. Who pays for the pizza? BMJ 31 May 2003: 326: 1189-1192
2. Department of Health. Commercial sponsorship - Ethical Standards for the NHS. November 2000

Our thanks to Marianne van-de-l'Isle, Principal Clinical Pharmacist, Pharmacy Department, Royal Edinburgh Hospital for contributing to this article.

Eureka for EUROPA?

What do we know?

Treatment with angiotensin-converting-enzyme (ACE) inhibitors has been proven to reduce the rate of cardiovascular events among patients with left-ventricular dysfunction and those at high risk of such events. The EUROPA study was designed to assess whether the ACE inhibitor perindopril reduced cardiovascular risk in a low-risk population with stable coronary heart disease and no apparent heart failure[1].

The EUROPA Trial

Design

Randomised, double blind, placebo controlled trial

Subjects

12,218 patients with established coronary heart disease (previous myocardial infarction, angiographic evidence of coronary disease, coronary revascularisation or a positive electrocardiogram, echo or nuclear stress test)

Treatment

ACE inhibitor perindopril (8mg once daily) or matching placebo

The primary outcome measures

Cardiovascular death, myocardial infarction or cardiac arrest

Result

There was a highly significant 20% relative risk reduction (95%, CI 9-29, p=0.0003) in the collective primary endpoint. The absolute risk reduction was 1.9%.

Lothian interpretation

Patients with established coronary heart disease are at a high risk of further events even in the absence of clinical heart failure. Perindopril therapy significantly improved outcome in this group of patients. Importantly, many patients were on secondary prevention measures, including 92% on antiplatelet therapy, 62% on beta-blockers, and 58% on lipid-lowering therapy. About 50 patients need to be treated for a period of 4 years to prevent one major cardiovascular event.

A major issue for local prescribers is whether perindopril specifically is required to achieve these benefits. The Lothian Formulary Committee believes that there is little compelling evidence to suggest that the benefits are anything other than a class effect of ACE inhibitors. Similar benefits have already been demonstrated with other agents that block the renin-angiotensin-aldosterone system.

Reference:

1. The EURopean trial On reduction of cardiac events with Perindopril in stable coronary Artery disease Investigators. The Lancet. 6 September 2003;362:782-8. Efficacy of perindopril in reduction of cardiovascular events among patients with coronary artery disease: randomised, double blind, placebo controlled, multicentre trial (the EUROPA study).
http://image.thelancet.com/extras/03art7384web.pdf

Key messages:

- **ACE inhibitors should be prescribed for all patients post MI, whether or not they have cardiac failure.**
- **GPs should review all patients with established CHD and unless contraindicated consider starting an ACE inhibitor.**
- **ACE inhibitors recommended in the LJF are enalapril, lisinopril and ramipril.**

New year competition - and the winner is …

Dr Sara Hornibrook, GP, Ferry Road

Thank you to all those who entered our competition. We are delighted to announce that a Hewlett-Packard iPAQ Pocket PC is on its way to Dr Hornibrook.

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