LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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In this issue ...

Risperidone and olanzapine
CSM advises do not use for behavioural symptoms of dementia

The Committee on Safety of Medicines (CSM) has considered new evidence relating to the use of risperidone and olanzapine in people with dementia[1]. Analysis of randomised controlled trials identified an approximate three-fold increase risk of cerebrovascular adverse events (including CVAs and TIAs) when using risperidone or olanzapine in dementia, compared to placebo. The CSM has advised that risperidone and olanzapine should not be used for behavioural symptoms of dementia.

- The CSM recommends that the use of risperidone for the management of acute psychotic conditions in elderly patients who have dementia be limited to short-term and under specialist advice (olanzapine is not licensed for management of acute psychosis).
- In addition, the CSM advise that prescribers carefully consider the risk of cerebrovascular events before treating any patient with a previous history of stroke or TIA or with cerebrovascular disease (e.g. previous CVA or TIA, hypertension, diabetes, current smoking, atrial fibrillation).
- The CSM warns of potentially similar risks with other antipsychotics in the absence of data proving otherwise.

The treatment of psychosis in people without dementia and with no history of CVA or TIA is unaffected by the CSM restriction. Short-term pharmacological treatment of behavioural disturbance and psychiatric symptoms associated with uncomplicated delirium is not affected.

The Lothian Joint Formulary recommends:

haloperidol *or* **sulpiride**

In the elderly, antipsychotics should be used with caution because of the side-effect profile, including extrapyramidal symptoms, sedation, anticholinergic effects, cardiovascular effects and tardive dyskinesia.
The LJF will be reviewed later this year as new evidence emerges.

Withdrawal of risperidone and olanzapine

In the first instance a trial of medication withdrawal over 2 to 4 weeks is recommended. A suggested mechanism is to reduce the dose by half with the aim of stopping the dose completely at week 4.

Withdrawal should *not* be undertaken in the following circumstances *(discussion with or referral to the local specialist mental health team is advised)*:

- Elderly people with a diagnosis of schizophrenia and a history of CVA/TIA
- People with continuing moderate to severe symptoms despite medication
- People with a history of serious risk to self or others
- Where medication withdrawal may prove problematic for other reasons

Treatment of new cases, or if severe behavioural disturbance or psychiatric symptoms emerge on withdrawal of medication

The use of medication should only be considered when non-pharmacological means have been ineffective or are not practical given the nature of the problem. It is indicated when there is psychosis, severe emotional distress or behaviour that is dangerous to the individual or others. As symptoms often resolve spontaneously, it is worth considering postponing treatment for a few days or using “as required” medication initially. There are currently no medicines with a specific license for use in managing behavioural disturbance and psychiatric symptoms in dementia.

Specialists and clinical pharmacists at NHS Lothian Primary & Community Division are issuing guidance on treatment options[2]. Copies are available from the Medicines Management Team, tel 0131 537 8573 or email prescribing@lpct.scot.nhs.uk.

References:

1. The Medicines and Healthcare products Regulatory Agency (MHRA). http://www.mhra.gov.uk/news/news.htm#atypical
2. ‘Atypical Antipsychotics and stroke’. Hospital and Specialist Services Medicines Committee, NHS Lothian - Primary & Community Division. Medicines Bulletin. Number 18, April 2004.

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Update on prescribing indicators for primary care

The Lothian Prescribing Indicators (PIs) have been in use for many years. Thirteen PIs have been developed by the Prescribing Budget Setting Group (a sub-group of the General Practice Prescribing Committee) for GPs. PIs are designed to encourage cost effective and quality prescribing and compliance with the Lothian Joint Formulary.

For 2004/05, targets for five PIs have been refined and two new PIs will be introduced. The new PIs are for isosorbide mononitrate and angiotensin-II receptor antagonists and are based on recommendations made in the recent Audit Scotland report on GP prescribing[1].

The generic PI will now be a 'gateway' to obtaining prescribing incentives. Practices failing to meet the generic target of 70% will not be eligible for any incentive payments.

It is recognised that prescribing in primary care is influenced by hospital clinicians. It is important that both primary and secondary care work together to achieve PIs to ensure the best use of NHS resources.

Practices will be sent full details of the budget setting process in the near future.

PI	Target	
GENERIC PRESCRIBING	Generic rate ≥ 70% per quarter	NEW GATEWAY TO INCENTIVE SCHEME WITH REVISED TARGET
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS	Cost per patient ≤ £1.14 for all oral and injectable NSAIDs per quarter	NO CHANGE
TOPICAL NSAIDs	Cost per patient ≤£0.10 per quarter	REVISED TARGET
TOTAL ANTIBIOTICS	Items per 100 patients ≤ 70 per annum	REVISED TARGET
CO-AMOXICLAV	Items per 100 patients ≤ 6 per annum	NO CHANGE
QUINOLONES	Items per 100 patients ≤ 3.5 per annum	NO CHANGE
BECLOMETASONE AS PERCENTAGE OF TOTAL NASAL STEROIDS	Total number of items ≥ 40% of all nasal steroids per quarter	REVISED TARGET
TRAMADOL	Cost per patient ≤£0.16 per quarter	NO CHANGE
ULCER HEALING DRUGS	New targets to be agreed depending on price of omeprazole	REVISED TARGET
HYPNOTICS INCLUDING TEMAZEPAM	Cost per patient ≤ £0.15 per quarter	NO CHANGE
LIPID AUDIT	Complete a Lipid Audit and return form every 3 years	NO CHANGE
MODIFIED RELEASE ISOSORBIDE MONONITRATE	Sliding scale Plain ISMN scripts as ratio of all ISMN scripts >= 10% per quarter Plain ISMN scripts as ratio of all ISMN scripts >= 20% per quarter	NEW PI
ANGIOTENSIN-II RECEPTOR ANTAGONISTS	Percentage of angiotensin-II receptor antagonist scripts of all scripts for renin system antihypertensives (ARAs + ACEIs) <= 25% per quarter	NEW PI

Reference
1. Audit Scotland. Supporting prescribing in general practice - a progress report. June 2003.

PPI News

Omeprazole is first choice PPI

The Formulary Committee **recommends omeprazole as the proton pump inhibitor (PPI) of first choice**. Generic omeprazole is now less expensive than lansoprazole. The orodispersible formulation of lansoprazole (Zoton FasTab®) should be reserved for patients with swallowing difficulties or who require a PPI by nasogastric tube or percutaneous endoscopic gastrostomy (PEG).

Helicobacter pylori eradication therapy

Increasing resistance to both clarithromycin and metronidazole has led to use of regimens which avoid this combination. The recommended treatment regimen for *H.pylori* eradication is now as follows:

First line therapy:	omeprazole	20mg twice daily for 1 week
	+ amoxicillin*	1g twice daily for 1 week
	+ clarithromycin	500mg twice daily for 1 week
Second line therapy:	omeprazole	20mg twice daily for 1 week
	+ amoxicillin*	1g twice daily for 1 week
	+ metronidazole	400mg twice daily for 1 week

* For patients allergic to penicillin replace amoxicillin with tetracycline 500mg twice daily.

Stepping down - changes to GORD management

The Lothian Dyspepsia guideline was launched on 17 September 2003[1] and reflects Lothian Joint Formulary (LJF) recommendations[2] and the recently published SIGN Guideline (68) Dyspepsia[3].

Previously a "step-up approach" to gastro-oesophageal reflux disease was advised starting with antacids and "stepping up" through H_2 receptor antagonists to PPIs. Although some controversy persists, there is increasing support for a "step-down" approach.

The guideline continues to advise antacid/alginate preparations for patients with mild or infrequent symptoms and acknowledges that satisfactory symptom suppression may be achieved with H_2 receptor antagonist or PPIs.

The guideline states: *'Step down' treatment, using a PPI initially, is now the most cost effective approach for GORD patients who require acid suppression therapy.*

For patients who require long-term maintenance therapy, acid suppression should be reduced to the minimum regimen that controls symptoms. In a minority of GORD patients, such as those known to have severe oesophagitis or peptic strictures, acid suppression therapy in excess of that required for symptom control may be needed. Specialist opinion is appropriate for these patients. *H.pylori* eradication is of no value in the treatment of GORD/heartburn. The LJF recommends starting with optimum doses of a PPI for patients with moderate to severe symptoms. An 'on demand' regimen is acceptable providing it is effective.

Key messages:

- **Omeprazole is LJF first choice PPI**
- **Zoton FasTab® should only be prescribed for patients with swallowing difficulties**
- **Please note the new treatment regimen for *H. pylori* eradication**
- ***H.pylori* eradication is of no value in the treatment of GORD/heartburn**

References

1. Lothian Dyspepsia Guideline, September 2003 www.nhslothian.scot.nhs.uk/primarycarelibrary/2_ClinicalPractice/home_cp.htm
2. The Lothian Joint Formulary www.ljf.scot.nhs.uk
3. SIGN Guideline (68) Dyspepsia www.sign.ac.uk/pdf/sign68.pdf

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

Reminder - do not prescribe these disallowed items

'Disallowed items' include items on a prescription which are blacklisted, outwith the limited prescriptions available to dentists and nurses, or limited to a specific 'form' type (GP10 or GP10A). Dressings that are incorrectly sized are also disallowed. Community pharmacists are not reimbursed for dispensing any of these items.

Some of the most common items that are disallowed include the following:

- Neo-Cytamen® injection
- Laxoberal®
- Some gluten free products, e.g. Glutafin® custard creams
- Certain blood glucose testing strips
- Lancets
- Needles
- Syringes
- Spot plasters
- Gloves
- Pregnancy testing kits
- Multistix®

In addition, drugs on the Selected List Scheme (SLS), e.g. sildenafil, tadalafil, Caverject®, may only be prescribed on the NHS in certain circumstances and are disallowed if prescriptions are not endorsed 'SLS'. Remember this list also includes drugs such as clobazam and vitamin B12 tablets.

Often items are disallowed due to inaccurate or incomplete endorsement of prescriptions. For example, only specific sizes of dressings, listed in the Drug Tariff, should be prescribed and prescriptions should be endorsed with the exact size dispensed.

Key messages:

- **Care should be taken to ensure that prescriptions are accurately and fully endorsed.**
- **Ensure that dressings are endorsed with the correct size as detailed in the Drug Tariff.**
- **Refer to Drug Tariff or the BNF to confirm which products may be prescribed on the NHS.**
- **Community pharmacists carry all financial implications of dispensing disallowed items.**

Additional information:

1. www.show.scot.nhs.uk/psd/Pharmacy/pharmacy_guidance.htm
2. Prescribing Bulletin Issue 112. November 2002. http://lpctweb/elib/3_LibInfoServ/8_News/LocalNewsletters/PrescribingBulletin/2002/PB112Nov02.pdf

Diethylstilboestrol* - supply problem resolved

Please note that a manufacturing problem has been resolved and supplies are now available from the wholesalers. Local specialists have advised that patients previously transferred to ethinylestradiol should be switched back to their previous dose of diethylstilboestrol.

** previously known as stilboestrol*

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