LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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In this issue …

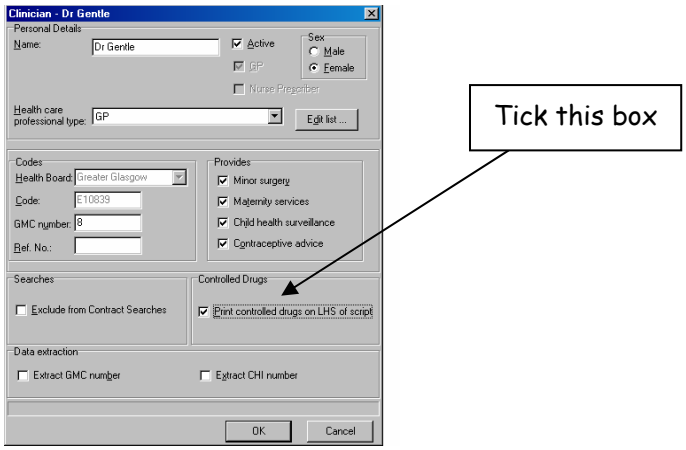
Controlled Drugs

Prescriptions no longer need to be handwritten

Controlled drug (CD) prescriptions no longer require to be written in the prescriber's own handwriting as from 14 November[1,2]. The following requirements still apply:

- the signature is handwritten by the person authorising the prescription
- the total amount of drug or the total amount of dose units in words and figures is specified
- the form of the preparation is specified (e.g. tablets, capsules)
- the content of the prescription is written in indelible format

GPs can configure the GPASS system to allow CDs to be printed on the left hand side of the prescription by simply ticking the box under controlled drugs in the GPASS Practice Configuration section.



Non-GPASS users may wish to contact their support teams for details on how to configure their own systems.

References

1. The Misuse of Drugs and the Misuse of Drugs (Supply to Addicts) (Amendment) Regulations 2005. www.opsi.gov.uk/si/si2005/uksi_20052864_en.pdf
2. The Misuse of Drugs Regulations 2001. Statutory Instrument 2001 No.3998. www.opsi.gov.uk/si/si2001/20013998.htm#15

The destruction of controlled drugs in primary care

Two clear messages came out of discussions at a recent Lothian Area Drug and Therapeutics Committee meeting.

Return of stock from GP practices

In agreement with Lothian and Borders Police it is advised that **no** practice CD stock should be returned to community pharmacies for destruction. GP practices should phone Mr Bill McKendry, Chemist Liaison Officer, Lothian and Borders Police (0131 311 3302) and he will, as an authorised signatory, come and destroy the medicines.

Patient returned CDs dispensed in a community pharmacy

The Royal Pharmaceutical Society of Great Britain has produced guidance[1]. CDs returned to the pharmacy from patients must not be reused and must be destroyed. It is now recommended good practice to record any patient returned CDs and to have their destruction witnessed by another member of staff. Ideally, CD denaturing kits should be used.

Reference

1. 'Destruction of controlled drugs'. Royal Pharmaceutical Society of Great Britain. November 2005. www.rpsgb.org.uk/pdfs/restooldestrcd.pdf

Osteoporosis Update

Calcium and Vitamin D Supplements

Two large-scale randomised trials have shown no benefit of calcium and vitamin D in the prevention of fractures. In the RECORD (Randomised Evaluation of Calcium Or vitamin D) study, 5,292 "ambulant, community dwelling subjects" (average age 77, 85% women) who had suffered a fragility fracture were randomised to receive placebo, calcium supplements alone (1000mg daily), vitamin D alone (800u daily), or calcium plus vitamin D supplements (1000mg/800u) to determine if any of these agents could reduce the risk of subsequent fracture[1]. There was no significant difference between fracture rates in any of the above treatment groups during a follow up period of between 2 to 5 years, indicating that calcium and vitamin D alone are not effective at fracture prevention in this patient group. Another study, based in primary care, randomised 3,314 elderly women (average age 70 years) with clinical risk factors for fracture to receive calcium and vitamin D supplements (1000mg/800u) or placebo for an average duration of about 2 years[2]. At the end of the study, there was no difference in fracture rates between the treatment groups.

The Lothian Joint Formulary (LJF) has been modified to indicate that calcium and vitamin D supplements alone are unlikely to be of benefit in reducing fracture risk in community dwelling ambulant subjects. Supplements may, however, still be of benefit in reducing fracture in elderly housebound or institutionalised individuals who are at high risk of calcium and vitamin D deficiency[3]. Whilst this change should see a downturn in calcium/vitamin D supplementation as 'stand-alone therapy' it is important to emphasise that virtually all randomised controlled trials of other bone active drugs such as bisphosphonates, raloxifene and calcitonin have used calcium and vitamin D as 'background therapy'. In view of this, it is recommended that calcium and vitamin D supplements should continue to be prescribed as an adjunct to other osteoporosis treatments.

Corticosteroid-induced Osteoporosis

The LJF previously recommended that treatment with bisphosphonates and calcium/vitamin D be considered in patients who are receiving prednisolone in doses of 2.5mg/day for more than 3 months. This recommendation was partly based on the fact that epidemiological studies have shown a slight increase in fracture risk, even in patients who are being treated with low dose steroids[4]. However, the evidence base with regard to therapy does not really support 2.5mg daily as an intervention threshold, since all of the randomised trials of treatment in corticosteroid-induced osteoporosis have focused on patients who are receiving ≥7.5mg/day of prednisolone daily for more than 3 months. The LJF has been updated with the new intervention threshold. Another notable change in this section has been made to acknowledge that both alendronate and risedronate (with calcium and vitamin D) are equally effective for the treatment of corticosteroid-induced osteoporosis in postmenopausal women.

Key messages:

- **There is no evidence for the use of calcium and vitamin D ALONE for primary or secondary prevention or treatment of osteoporosis in community dwelling ambulant patients.**
- **Continue calcium and vitamin D in elderly housebound or institutionalised individuals at high risk, and those on additional osteoporosis treatments.**
- **The new threshold in the LJF for the treatment of corticosteroid-induced osteoporosis is ≥7.5mg/day of prednisolone daily for more than 3 months.**
- **Refer to the LJF section 6.6 for full details**
  www.ljf.scot.nhs.uk/exist/xmldb/db/ljf_v2/unified/unified6_6.xml

References

1. Grant AM *et al*. Oral vitamin D3 and calcium for secondary prevention of low-trauma fractures in elderly people (Randomised Evaluation of Calcium Or vitamin D, RECORD): a randomised placebo-controlled trial. *Lancet* 2005;*365*:1621-8.
2. Porthouse J *et al*. Randomised controlled trial of calcium and supplementation with cholecalciferol (vitamin D3) for prevention of fractures in primary care. *Br Med J* 2005;*330*:1003-6.
3. Chapuy MC *et al*. Vitamin D3 and calcium to prevent hip fractures in the elderly women. *N Engl J Med* 1992;*327*:1637-42.
4. van Staa TP *et al*. The epidemiology of corticosteroid-induced osteoporosis: a meta-analysis. *Osteoporos Int* 2002;*13*:777-87.

Thanks to Professor Stuart H Ralston, ARC Professor of Rheumatology, University of Edinburgh for contributing this article. Thanks also to Anne Kinnear, Clinical Pharmacist, Medicine of the Elderly.

Winter 'Flu - a Reminder on Antivirals for Prophylaxis and Treatment

This is an update on the use of antiviral drugs for influenza as a follow-up to the article that appeared in a previous issue of the Lothian Prescribing Bulletin[1]. **This article is not about pandemic 'flu or avian 'flu.**

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 at-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[2,3] on the use of antiviral drugs for people in at-risk* groups when influenza is circulating in the community. This was endorsed by NHS Quality Improvement Scotland.

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	Post exposure prevention	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

Oseltamivir and zanamivir have been added to Schedule 2 of the NHS circular 'Standard GMS Contract Lists of drugs subject to prescribing controls'[4]. They may only be prescribed on the NHS for 'at-risk' patients and prescriptions must be endorsed 'SLS'.

Key messages:

- **These drugs are not a substitute for vaccination.**
- **Antiviral drugs for post exposure prevention or 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. Lothian Prescribing Bulletin. Issue 6 (Dec 2003/Jan 2004). www.ljf.scot.nhs.uk/lpb/LPB6.pdf
2. Guidance No. 58: www.nice.org.uk/pdf/58_Flu_fullguidance.pdf
3. Guidance No. 67 www.nice.org.uk/pdf/67_Flu_prophylaxis_guidance.pdf
4. Standard General Medical Services Contract Lists of drugs subject to prescribing controls. PCA(M)(2005)2. Scottish Executive. 22 February 2005. www.show.scot.nhs.uk/sehd/pca/PCA2005(M)02.pdf

Mistletoe just for Kiss-mas?

European mistletoe (*Viscum album*) is a parasitic plant that grows on deciduous trees, including pine, oak, apple, maple and numerous others, extracting water and nutrients from the host tree. The chemical constituents of European mistletoe as a medicine therefore depend on the type of host tree. The identified constituents of mistletoe include lectins, viscotoxins, alkaloids and flavonoids.

Most recent traditional uses for European mistletoe include hypertension, hypertensive headaches, nervous tachycardia, chorea, hysteria and treatment of some cancers. The mechanism of action for its hypotensive effects remain unclear, most of the documented pharmacological studies for mistletoe have concentrated on the cytotoxic and immunostimulant properties of the plant. The mode of action for the cytotoxic activity has been linked to the ability of the amino acids to maintain cell differentiation. The immunostimulant activity is attributed to stimulation of the monophagocytic system, increasing the number and activity of neutrophils.

Mistletoe extracts are widely used in Europe (especially Germany and Switzerland) in the treatment of cancer. It is used as an adjunct to conventional chemotherapy and radiotherapy and also as a single agent. Systematic reviews of cancer trials have found that many of the studies lack the evidence to support the efficacy of mistletoe extracts as a cancer treatment.

European mistletoe is used orally or injected subcutaneously. Patients should be discouraged from relying on mistletoe alone in the treatment of cancer. Oral treatment is well tolerated and doesn't cause too many adverse effects at small doses. Large amounts can cause significant toxicity. The adverse effects being vomiting, diarrhoea, intestinal cramps, hepatitis, hypotension, contraction of the pupil, uncontrollable eye movements, seizures, coma and death. Subcutaneous use can lead to pain at the injection site, chills, high fever, headaches, angina, eosinophila and allergic reactions.

There are a number of drug interactions associated with the use of European mistletoe. It may interfere with existing cardiac medication, immunosuppressant drugs, blood pressure medication, antidepressants, anticoagulants and coagulant therapies.

An alternative use for mistletoe that we are all familiar with involves kissing. There are a number of origins for the Christmas tradition of kissing under a sprig of mistletoe (willingly or otherwise). The earliest documented case is from the 16th century and may be related to beliefs that the mistletoe had beneficial effects on fertility and conception. Another interpretation is that an exchange of kisses is a promise to marry and a prediction of happiness and a long life.

Reference sources

- Barnes J *et al.* Why Mistletoe is a Kiss-mass plant! *Pharm J* 2003;*271*:854-5. www.pjonline.com/pdf/xmas2003/pj_20031220_mistletoe.pdf
- European Mistletoe. Natural Medicines Comprehensive Database. www.naturaldatabase.com accessed 25/11/05

eLJF-GPASS v2005.1

The latest version of eLJF-GPASS was circulated to over one hundred GP practices in November 2005. This update includes the latest changes to the LJF up to October 2005; it also includes the new Lothian Formulary for Children.
eLJF-GPASS users should ensure that they have upgraded their systems to this latest version.

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