LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 22

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In this issue ...

The Lothian Minor Ailments Formulary

Supporting safe and effective treatment in community pharmacies

The **Lothian Minor Ailments Formulary (MAF)** for adults and children has been developed by a multidisciplinary working group as part of the Lothian Joint Formulary (LJF). The MAF is designed to support the Minor Ailment Service (MAS) element of the new community pharmacy contract, launched in July 2006. It is based on the national formulary for MAS, in turn based on the British National Formulary. The MAF includes Pharmacy (P), Pharmacy Only (PO) and General Sales List (GSL) medicines that are not blacklisted, dressings and appliances, and any Prescription Only Medicines (POMs) which are underpinned by MAS national Patient Group Directions (PGDs). Currently 2 PGDs are in use, chloramphenicol eye drops and fluconazole 150mg capsules.

Consulting and advising on the treatment of minor ailments has always been a core role provided by community pharmacists. The MAS allows patients (including children), who are exempt from prescription charges, to register with, and use a community pharmacy for the treatment of common illnesses on the NHS without having to see a doctor. Once a patient has registered with their community pharmacy they can present at any point with symptoms and the pharmacist will treat, advise or refer them to another healthcare practitioner where appropriate.

Pharmacists are encouraged to prescribe in line with national and local prescribing policy and guidance (e.g. LJF) to support evidence-based, cost effective prescribing decisions, and to prescribe generically, where possible.

The MAF will be produced in a folder for each community pharmacy and will also be available on the Internet at www.ljf.scot.nhs.uk or www.communitypharmacy.scot.nhs.uk/HealthBoards/lothian.html. An abbreviated version of the MAF has been distributed to community pharmacies.

SKIN Sample page

(a) Acne

ADULT

First choice:	**benzoyl peroxide**

Dose/Quantity

- Benzoyl peroxide *2.5%* 40g aquagel: apply 1-2 times daily.
- Benzoyl peroxide *5%* 40g aquagel: apply 1-2 times daily.
- Benzoyl peroxide *10%* 40g aquagel: apply 1-2 times daily.

Prescribing notes

- Topical treatment takes at least 30 days to become effective.
- Benzoyl peroxide should be used in increasing strengths regularly to the entire acne-prone area.
- May bleach clothing.

When to advise patient to contact GP

Acne in the very young
Severe acne
Acne causing scarring
Failed medication (no improvement in 2 months)
Suspected drug-induced acne

Thanks to Sean MacBride-Stewart, Formulary Pharmacist, NHS Lothian, for contributing to this article.

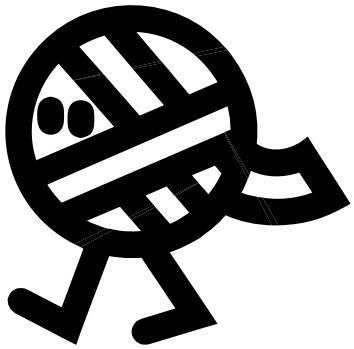
Wound Management - new LJF section

Lothian Joint Formulary (LJF) recommendations for wound management products have been developed by a multidisciplinary team of tissue viability nurses, community nurses, podiatrists, general practitioners and community pharmacists. The LJF recommendations reflect current evidence and best practice, with comprehensive prescribing notes, and can be found within the skin chapter of the adult formulary (section 13.13).

Expenditure on wound management products and bandages in primary care in Lothian was £1.7 million in the last financial year. The rise in expenditure is attributable to both a rise in cost of items (an average of 10% per annum) but also changing workload, with more complex wound care now being provided outwith the hospital setting.

The wound management section will be available on the LJF website - www.ljf.scot.nhs.uk - and paper copies will also be distributed in the near future.

An LJF wound management stand will be displayed at the Directorate of Nursing Best Practice Conference, to be held at the Royal Infirmary of Edinburgh on 15 November 2006. It is hoped that copies of the LJF wound management section will be available at this event.



An NHS Education for Scotland Pharmacy evening training session on wound management has been organised for 13 March 2007, to be led by Linda Primmer, Tissue Viability Nurse.

Thanks to Sean MacBride-Stewart, Formulary Pharmacist, NHS Lothian, for contributing to this article.

Controls on the promotion of prescription medicines

The Association of the British Pharmaceutical Industry (ABPI) has reviewed their Code of Practice. The Code regulates promotion of prescription medicines in the UK through the Prescription Medicines Code of Practice Authority (PMCPA). The PMCPA operates as a self-regulatory process. Some of the changes are:

- All printed promotional material to provide information about reporting adverse events.
- Restrictions on sponsored travel and hospitality.
- Increased guidance on the provision of information to the public.
- Further limitations on the amount of advertising.
- Additional sanctions introduced and changes made to speed up the complaints procedure.

Hospitality can only be provided to health professionals and managers as part of scientific or promotional meetings. Hospitality must be secondary to the meeting, and of an appropriate standard. Lavish or deluxe venues must not be used. Only economy air travel can be provided when delegates are sponsored to attend meetings.

Samples of medicines can only be supplied in response to written requests and no more than 10 samples of a medicine will be provided in the course of a year to health professionals qualified to prescribe that medicine.

Prescription-only medicines must not be advertised to the public, with the exception of vaccination campaigns approved by health ministers. Non-promotional information can be provided to the general public directly or via the media.

Complaints - if you are concerned about the way a medicine has been promoted by a pharmaceutical company, please discuss it with a member of your Medicines Management Team and bring it to the attention of the Lothian Area Drug and Therapeutics Committee (ADTC), who may be able to assist you in reporting a complaint to the ABPI if required. Complaints should be referred to the director of the PMCPA. The full Code of Practice 2006 can be viewed online at www.pmcpa.org.uk.

eLJF-GPASS v2006.1 upgrade

The latest version of eLJF-GPASS will shortly be circulated to all practices by email. Please ensure that you upgrade your GPass system with this latest version.

EPASS accredited CPD packs for new users of eLJF-GPASS are available free of charge from the Medicines Management Team.

Comments and feedback on eLJF-GPASS developments are always welcome.

Migraine and cluster headache - OUCH!

Amendments have been made to the Lothian Joint Formulary (LJF) section on the management of migraine and cluster headache www.ljf.scot.nhs.uk. Although simple analgesics are an effective acute treatment for many patients with migraine, prescribers are alerted to the risk of medication overuse headache with these agents, especially when they are taken in combination with opiates such as codeine.

The section on the use of triptan drugs for acute, moderate to severe migraine has been expanded to reflect differences in efficacy and adverse events. Choice of alternative triptans is guided by the patient's response to sumatriptan. Almotriptan is an effective alternative when sumatriptan is not tolerated, but with a lesser risk of causing side effects. Rizatriptan may be effective when sumatriptan fails to give adequate relief, but this can be at the expense of more side effects. All acute treatments for migraine have maximal efficacy when taken early in an attack. As with the analgesics, there is a risk of medication overuse headache if triptans are used more than 4 times a week. A balance between early treatment and risk of overuse needs to be struck. If oral treatments are ineffective for acute attacks, nasal zolmitriptan or subcutaneous sumatriptan can be tried.

For migraine prophylaxis, the beta-blocker atenolol is the recommended first choice medicine. It is not licensed for migraine prophylaxis but is considered to be a cost effective choice.

The antiepileptic drug sodium valproate (also not licensed for this indication) is now the second choice for migraine prophylaxis. Liver function should be monitored and women of child-bearing potential should be advised to use adequate contraception and be made aware of the potential risks. The more sedative drugs pizotifen and amitriptyline may also be considered. Prophylaxis should be considered in patients having more than 3 acute attacks per month, or where less frequent attacks are very severe or prolonged. Prophylaxis is usually given for 3 to 6 months, during which time the patient should be kept under regular review.

The section on cluster headache has been altered slightly. Subcutaneous sumatriptan remains the mainstay for acute attacks, but nasal sumatriptan or zolmitriptan can be tried if the subcutaneous route is unsuitable for the patient. The use of high-flow oxygen by inhalation in the management of acute attacks is also included. A high-flow regulator and a tight fitting mask must be obtained to achieve the required level of oxygen flow. These items are not prescribable on GP10. The mask can be obtained from the Department of Clinical Neurosciences clinic. Further information on obtaining a high-flow regulator can be found on the Organisation for the Understanding of Cluster Headache (OUCH) website www.clusterheadaches.org.uk.

The use of short courses of oral prednisolone for prophylaxis has also been added, but is suitable only for patients with relatively short cluster bouts.

Key messages:

- **Be alert for medication overuse headaches, especially with combination formulations. Triptan overuse can also cause daily headaches.**
- **Oral sumatriptan 50mg at onset of headache is first choice treatment for acute migraine attacks.**
- **In severe migraine attacks resistant to oral medication, consider nasal zolmitriptan or subcutaneous sumatriptan.**
- **First choice medicine for migraine prophylaxis is atenolol.**

Thanks to Dr Roger E Cull, Department of Clinical Neurosciences, Western General Hospital, and Maureen Reid, Primary Care Pharmacist, South West Edinburgh LHP, for contributing to this article.

Pregabalin (Lyrica®)

Pregabalin (Lyrica®) is not recommended for use by the Scottish Medicines Consortium (SMC) within NHS Scotland for the treatment of peripheral neuropathic pain in adults. This advice follows an Independent Review Panel Assessment undertaken after the SMC had twice previously not recommended pregabalin for this indication.

The SMC advice states that "comparative clinical and cost effectiveness have not been demonstrated. Further controlled data are needed to establish its place in therapy in patients refractory to or intolerant of other pharmacological treatments".

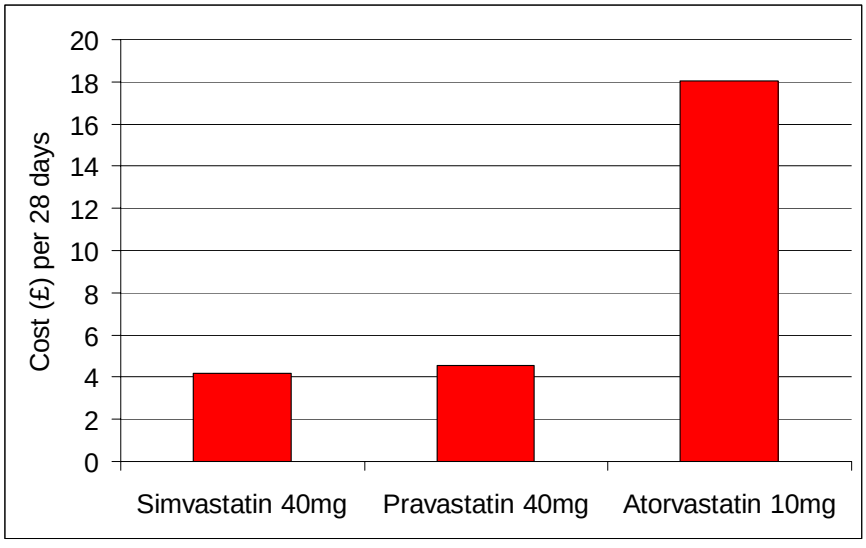
Statin' the facts

Several large-scale randomised controlled trials have established that using statins to lower cholesterol prevents future cardiovascular events, and have resulted in a 30% year-on-year rise in prescribing of these drugs. A degree of confusion persists, however, with respect to differences between primary and secondary prevention, treatment targets, and whether certain statins are better than others.

Statins have beneficial effects in both primary and secondary prevention. For primary prevention, the Joint British Societies consider the starting point for prevention to be a 10 year cardiovascular disease event risk of 20% or more, and not simply serum cholesterol which alone is a poor predictor of risk. Secondary prevention should be considered in persons with established vascular disease and a total cholesterol of over 3.5mmol/L. The cardiovascular relative risk reduction is similar regardless of factors such as age, sex, presence of diabetes, blood pressure, or pre-existing vascular disease. Statins have also been shown to reduce the risk of cardiovascular events even in people with a low (6%) 10 year coronary heart disease risk, but treatment of this population is not advocated by current Joint British Societies guidelines and is not considered cost effective.

There is a linear relationship between the absolute reduction in LDL cholesterol and the reduction in cardiovascular events. Lowering LDL cholesterol by 1mmol/L therefore results in a similar reduction (around 23%) in cardiovascular risk, regardless of the baseline cholesterol. However, patients with a total serum-cholesterol concentration of 5 mmol/L or greater are likely to benefit most in absolute terms. There has not been shown to be a lower-limit below which further cholesterol reduction is not beneficial. However, the risk of problems such as myopathy is dose dependent, and higher doses of statins may therefore result in clinically relevant adverse effects. The Lothian recommended targets are a reduction of total cholesterol of 25%, or the GMS contract target of 5mmol/L for primary prevention.

The Lothian Lipid Guideline first choice statin is simvastatin, as it is considered more cost effective than the alternatives. Second choice statin is atorvastatin. In people not achieving target with simvastatin 40mg, atorvastatin may be used. A recent study concluded that pravastatin, simvastatin and atorvastatin, when used in their standard doses, had similar effects on cholesterol levels, and no significant difference in the degree of cardiovascular risk reduction[1]. Pravastatin is less likely to interact with other drugs than atorvastatin or simvastatin, and may be preferred in certain situations, such as in patients receiving warfarin, digoxin or ciclosporin. Simvastatin 80mg is not recommended in Lothian due to the risk of adverse effects. The Lothian Formulary Committee has recently reviewed current evidence on statins and supports initiatives to switch patients on low-dose atorvastatin to simvastatin 40mg.



This graph shows costs based on 28 days treatment. Doses are those considered to be of equal efficacy in terms of cardiovascular risk reduction[1]. Prices are based on current MIMS prices and the Scottish Drug Tariff.

Reference

1. Zhou Z, Rahme E, Pilote L. Are statins created equal? Evidence from randomized trials of pravastatin, simvastatin, and atorvastatin for cardiovascular disease prevention. *Am Heart J*. 2006;151:273-81

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