LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 24

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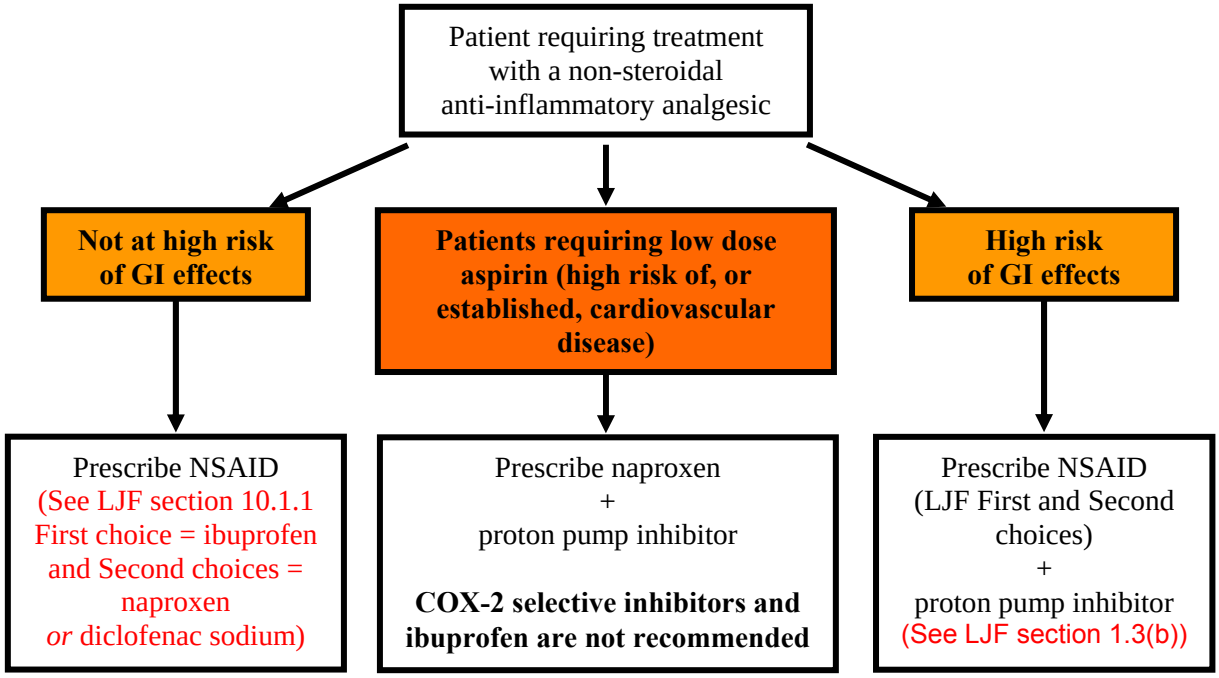
In this issue ...

Safety update on NSAIDs

The Medicines and Healthcare products Regulatory Agency (MHRA) published new safety advice in October 2006 relating to non-steroidal anti-inflammatory drugs (NSAIDs), including COX-2 selective inhibitors, used in high doses and for long-term treatment[1], which stated *"Non-selective NSAIDs may be associated with a small increased risk of thrombotic events (such as heart attack or stroke) when used at high doses and for long-term treatment"*. This follows previous cardiovascular safety advice in August 2005[2]. This information has been reviewed by the LJF Rheumatology Working Group and the Lothian Prescribing Guideline for the use of NSAIDs has been revised[3] (see illustration below, adapted from guideline).



Key messages:

- **For all patients the balance of gastrointestinal and cardiovascular risk should be considered before prescribing any NSAID.**
- **The lowest effective dose of NSAID or COX-2 selective inhibitor should be prescribed for the shortest time necessary for control of symptoms.**
- **Patients on long-term treatment should be reviewed periodically.**

References

1. Safety of selective and non-selective NSAIDs. Scottish Executive. 24 October 2006. www.mhra.gov.uk
2. Cardiovascular safety of NSAIDs review of evidence. Scottish Executive. 2 August 2005. www.mhra.gov.uk
3. Lothian Prescribing Guideline for the use of NSAIDs. Rheumatology Working Group. July 2006.
4. The Drugs Don't Work. The Verve. September 1997.

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

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

U2 told us what you think of the LPB

A questionnaire was distributed to doctors, nurses, health visitors and pharmacists in primary care and hospitals in Lothian. This, and subsequent analysis, was undertaken on behalf of the Lothian Prescribing Bulletin (LPB) Editorial Team by Dr Rupert Payne, Lecturer in Clinical Pharmacology, and Mr Edmund Rhatigan, medical student.

The questionnaire aimed to gauge level of use, assess readers' view on the content and readability, and evaluate whether it changed practice. 833 individuals responded, with most responses from GPs and junior hospital doctors (Figure 1 - American Pie chart).

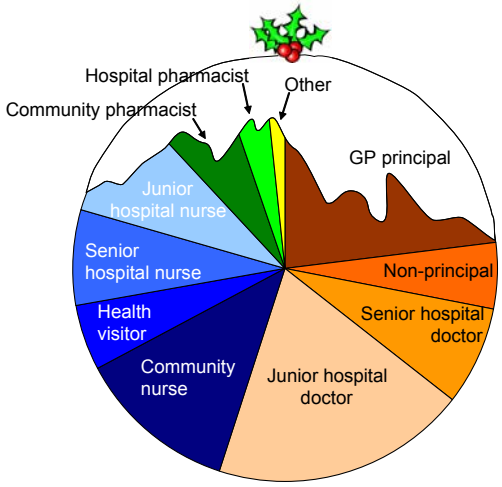


Figure 1 - respondents to questionnaire

How well is it used?

- Awareness Level 42 was high. In primary care, 96% of respondents had heard of the LPB, including 83% of non-principal GPs. In hospitals: pharmacists (100%), senior doctors (89%), nurses (81%), junior doctors (68%), junior nurses (48%).
- Distribution of bulletins varied widely with high levels in community (89%) and lower levels in hospital, with junior staff rarely receiving a copy (26%).
- Figure 2 shows that it is generally well Simply Red by those who receive it.

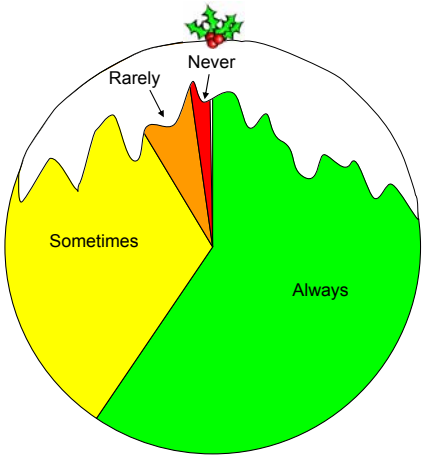


Figure 2 - how often is the LPB read?

- It was not well known that the LPB is available on the LJF website - www.ljf.scot.nhs.uk (approximately 40% in primary care and 50% in hospitals).
- Around three quarters of those in primary care would prefer to receive a paper version of the bulletin. In hospitals, doctors showed little preference over email (42%) or paper (43%). Hospital pharmacists preferred email (56%) and hospitals nurses paper (51%).

Readers' view on content and readability

- Figure 3 shows that overall rating for usefulness was high. Respondents said that the LPB is clear and easy to read, with a median rating of 4 (good). In particular, the ratings were highest for communication of important and topical prescribing issues and drug safety issues.

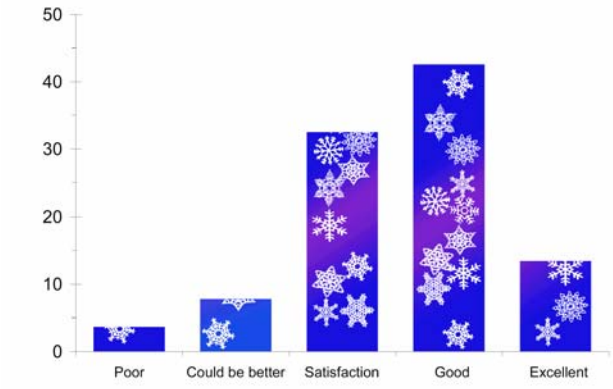


Figure 3 - overall usefulness of the LPB

- 96% of readers considered the tone of articles to be just right and 91% felt that the LPB was the right length.

Does the LPB influence practice Ch-ch-ch-ch-changes?

- 95% of GP principals thought it did but only 31% of junior hospital nurses (see Figure 4).

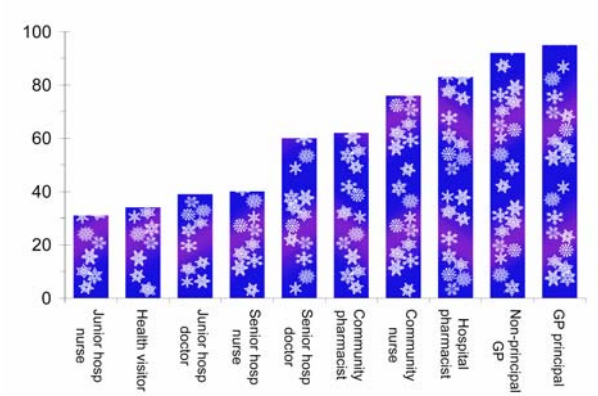


Figure 4 - does the LPB influence your prescribing?

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Our Conclusions

This is useful feedback with a sufficiently high level of response to be meaningful.

The Editorial Team were pleased to learn that awareness of the bulletin is high, it is generally well read and it is rated high for usefulness and communication of issues. The Editorial Team frequently discuss whether articles are the right length and whether the tone is right and are very pleased to learn that over 90% of readers think we achieve this.

However, before we start to celebrate this Perfect Day we must consider whether there are any lessons to learn. We are not entirely successful in getting bulletins to junior hospital staff, should consider reporting more frequently on new drug trials, and need to raise awareness of the availability of the LPB on the LJF website - www.ljf.scot.nhs.uk.

The LPB Editorial Team would like to thank all respondents.

Medication errors involving morphine and oxycodone

There have been errors reported arising from confusion between normal (quick) release and controlled release oral opioid preparations. The errors involve morphine and oxycodone and include the wrong dose given and the wrong preparation prescribed, dispensed or administered.

Morphine sulphate oral - normal (quick) release

Onset of action of about 20 minutes and reach peak levels at about 60 minutes. They have a duration of action of 3 to 4 hours. They are sometimes referred to as 'quick release' or 'immediate release'.

These preparations are used in initiating therapy for moderate to severe pain and for treating breakthrough pain in palliative care.

Some examples of these types of preparations are:

- tablets 10mg, 20mg, 50mg (Sevredol®)
- liquid 10mg/5mL (Oramorph®)
- concentrated liquid 100mg/5mL (Oramorph® concentrated).

Morphine sulphate oral - controlled release

These preparations have a slower onset of action and are also referred to as 'modified release' or 'long acting'. There are 2 types of controlled release morphine sulphate preparations; those that are administered every 12 hours and those that are administered every 24 hours.

Many of the 12-hourly preparations have an onset of action of 1 to 2 hours and reach peak drug levels at 4 hours.

These preparations are used when pain is controlled. They are **not** used for breakthrough pain.

Some examples of 12 hour preparations are:

- tablets 5mg, 10mg, 15mg, 30mg, 60mg, 100mg, 200mg (MST Continus®)
- tablets 10mg, 30mg, 60mg, 100mg (Morphgesic® SR)
- capsules 10mg, 30mg, 60mg, 100mg, 200mg (Zomorph®)

Oxycodone

Dazed and Confused errors often also occur between the controlled release preparation of oxycodone (OxyContin®) and the normal (quick) release preparation (OxyNorm®).

Lothian Joint Formulary

Morphine sulphate is the first line oral opioid for moderate to severe pain.

Do not use oral oxycodone first line. Oral oxycodone may be prescribed on specialist advice for patients in whom morphine is ineffective or not tolerated.

Managing the risk

There are a number of key points to be considered at the point of prescribing, dispensing or administering to the patient:

- Ensure that prescriptions for oral morphine and oral oxycodone clearly state 'controlled release' where appropriate.
- Provide information/explanation about the preparation to the patient at the time of prescribing/dispensing or administering, this may alert you and the patient to a potential error.

The Lothian Palliative Care Guidelines provide both advice on managing pain in palliative care, and patient information leaflets on strong opioids (www.scan.scot.nhs.uk).

Key messages:

- **Ensure that prescriptions for all formulations of morphine sulphate or oxycodone are clear.**
- **Ensure that prescriptions for oral morphine and oral oxycodone clearly state 'controlled release' where appropriate.**
- **Double-check what formulation is required to ensure that the patient gets the correct medicine.**

Thanks to Dorothy McArthur, Principal Pharmacist, Marie Curie and St Columba's Hospices, for contributing to this article.

Updated guidelines for managing hypertension (The Song Remains the Same)

The The NICE/British Hypertension Society guidance on blood pressure management was recently updated. Treatment thresholds (>160/100 mmHg, or >140/90 mmHg in higher risk individuals) and targets (<140/90 mmHg) remain unchanged. The guidance was not felt to necessitate a change in the current Lothian Hypertension Guidelines, and was clarified in a letter sent to all GPs in Lothian in October 2006. The key Lothian recommendations are summarised below:

- In Lothian, thiazide diuretics remain the first choice treatment for patients aged ≥50 years, or black patients of any age; calcium channel blockers (CCB) are an alternative.
- ACE inhibitors remain the first choice in patients aged <50 years.
- If initial treatment was with a CCB or thiazide and a second drug is needed, an ACE inhibitor should be used. If initial treatment was with an ACE inhibitor, add a CCB or thiazide.
- If 3 drugs are required, a combination of ACE inhibitor, CCB and thiazide should be used.
- Beta-blockers are not preferred as routine initial therapy.
- In patients with hypertension controlled with beta-blockers, there is no urgent need to change to an alternative drug. If BP is not controlled with a beta-blocker, then treatment should be revised accordingly, particularly if there are risk factors for diabetes (obesity, family history, thiazide treatment). Withdrawal of beta-blockers should be gradual.
- If initial treatment was with a beta-blocker, and a second drug is required, a CCB is usually preferred over a thiazide to reduce the risk of diabetes.
- Coexisting ischaemic heart disease and chronic heart failure remain compelling indications for beta-blockers.

Festive quiz

Did you spot the 23 references to songs/artists in this bulletin?

Whilst these have been used for the purposes of the quiz, we do not wish to minimise the importance of the key messages contained in this bulletin!

We would like to wish all of our readers a very Merry Christmas and a Happy New Year!

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