LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 27

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In this issue ...

We're all going on a summer holiday...

With summer holidays approaching, we thought it worthwhile to remind readers of important prescribing matters relating to travel abroad.

Travelling abroad with prescription drugs

Home Office guidance (www.drugs.gov.uk) states that both controlled drugs, and non-controlled prescription drugs, must be in the original packaging and carried in hand luggage. Travellers should contact the Embassy or Consulate in the destination country (or any other country through which they might be travelling) to enquire about any restrictions.

The British Airport Authority (BAA) guidance states that liquid medications over 50mL are not permitted in hand luggage and should be discussed with the airline. Volumes under 50mL may be permitted subject to verification by taste or by the airport pharmacist. For details visit www.baa.com/assets/B2CPortal/Static%20Files/hand_baggage31Aug.pdf

Individual airline guidance should be checked prior to travel.

Non-controlled prescription drugs should be carried with a copy of the repeat prescription or a note from the prescribing doctor.

Controlled drugs must be carried with a letter from the prescribing doctor confirming the patient's name, address, date of birth, outward and return dates of travel, the country being visited, and the list of drugs carried, including dosage and total amounts. In addition, a valid personal import/export licence is required if travelling for 28 days or more. Application forms and a list of restricted drugs are available at www.drugs.gov.uk/drugs-laws/licensing/personal/.

It is important to remember that a personal licence has no legal standing outside the UK and is intended to allow travellers to pass through UK customs unhindered. Travellers should therefore check with the relevant Embassy or Consulate for regulations or restrictions.

Vaccinations

Overseas travel may expose travellers to a range of infectious diseases. The NHS provides free access to vaccinations for patients against diseases that could pose a public health risk if imported into the UK. These are hepatitis A, typhoid, poliomyelitis, typhoid/hepatitis A combination, smallpox and cholera. Other vaccines that may be required should be prescribed on a private prescription.

Malaria prophylaxis and other medicines

Malaria prophylaxis is not available on an NHS prescription. Chloroquine and proguanil are available over the counter and other prophylactic agents require a private prescription. Patients requesting other medicines, e.g. antibiotics, acetazolamide, in case they fall ill abroad, can be issued with a private prescription if deemed appropriate.

Supplies of chronic medication

Patients intending to stay abroad for long periods of time may no longer be regarded as UK residents, and would therefore not be entitled to NHS services. In this situation they should be given sufficient medication to allow them time to access supplies from a local medical service abroad. A period of up to 3 months is generally agreed to be appropriate. It may not be in the patient's best interest to continue to take medication that is not being monitored adequately, and where a change of climate may affect the course of the disease.

Take heart - changes to LJF cardiovascular section

The Lothian Joint Formulary (LJF) is a dynamic document and is updated monthly to keep pace with required change. The full LJF is only available via the website www.ljf.scot.nhs.uk. Some of the recent changes made to the cardiovascular section are highlighted below. The section was reviewed in conjunction with the recently published SIGN guidelines (Numbers 93 to 97) issued in February 2007.

2.3 - Anti-arrhythmic drugs

Patients requiring long term treatment with amiodarone should have the following tests performed before treatment is commenced. Consideration should also be given to repeating them in patients who remain on long term treatment.

- liver function and thyroid function tests (repeated 6-monthly)
- chest x-ray
- lung function tests (spirometry, lung volumes and gas transfer).

2.4 - Beta-adrenoceptor blocking drugs

First choice:	**atenolol** *or* **bisoprolol**

The choice of beta-blockers is no longer differentiated by indication.

2.5.5.2 - Angiotensin-II receptor antagonists

Heart Failure or hypertension
First choice: **candesartan**

Diabetic nephropathy in type 2 diabetes mellitus
First choice: **irbesartan**

Angiotensin-II receptor antagonists (ARAs) should be reserved for patients who develop a persistent cough with ACE inhibitors. Losartan is no longer second choice. Patients should have urea and electrolytes measured within 2 weeks of commencing therapy (ARAs and ACE inhibitors).

2.6.2 - Calcium-channel blockers

Hypertension
First choice: **amlodipine**

Angina

- patients not receiving beta-blocker
First choice: **diltiazem**
or **verapamil**

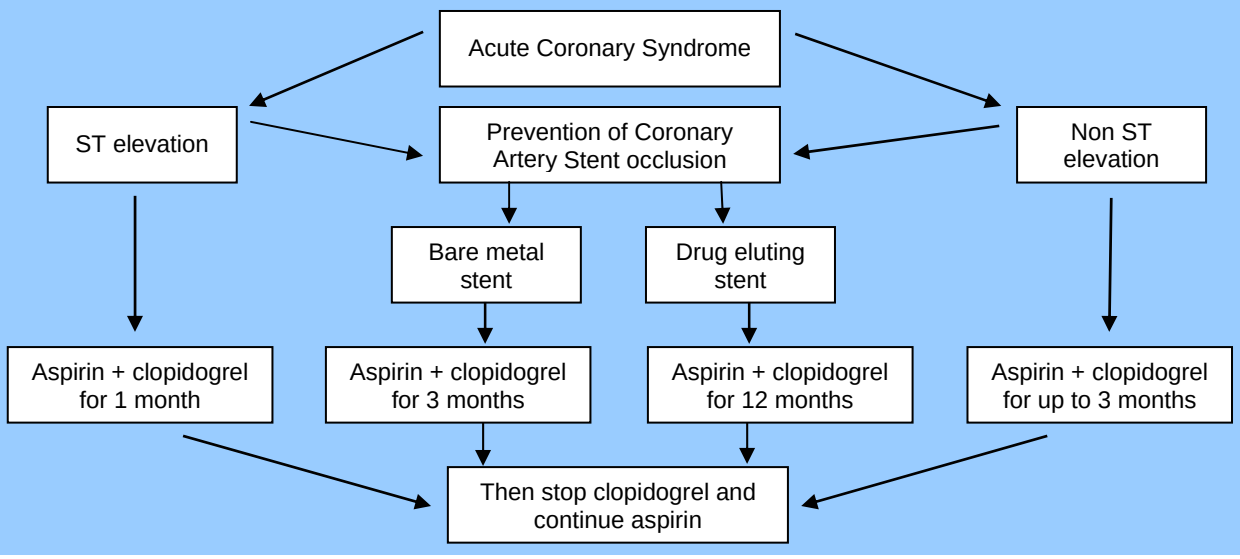
- patients receiving beta-blocker
First choice: **amlodipine**

Supraventricular arrhythmias
First choice: **verapamil**

Nifedipine is no longer an LJF choice.
Generic amlodipine is now available and unlike nifedipine does not require to be prescribed by brand name.

2.9 - Antiplatelet drugs

Guidance for treatment with clopidogrel has been reviewed with regard to SIGN 93. The following flow chart outlines the new guidance. Note, in particular, the recommendations on duration of treatment.



LJF updated guidance - oral nutritional supplements

Following a recent update of the oral nutritional supplements (ONS) section of the LJF, the main points are:

- ONS should not be regarded as a first line treatment of undernutrition and should always follow dietary intervention.
- ONS should be commenced on the advice of a registered dietitian.
- Where appropriate a 1.5kcal/mL supplement rather than a 1.0kcal/mL supplement should be prescribed.
- The dietitian should advise the patient that the use of ONS will initially be a trial period of up to 3 months. They will provide 7 days initial supply of ONS before requesting a prescription and advise on the schedule for administration.
- The dietitian should request a prescription for a 4-week supply of ONS from the GP and continue to assess the need for patient's ongoing ONS prescription.
- Patients should not receive ONS prescribed for other patients.
- Prescribers should refer to local guidance for advice on when to prescribe supplements for drug misusers[1], but refer to LJF recommendations on the choice of preparation.

LJF recommendations

Milk Style **First choice:**	**Clinutren® 1.5 200mL** *or* **Fortisip Bottle® 200mL**
Yoghurt Style **First choice:**	**Fortifresh® 200mL**
Fruit Juice Style **First choice:**	**Clinutren® Fruit 200mL** *or* **Fortijuce Bottle® 200mL**
Milk Style with fibre **First choice:**	**Clinutren 1.5 Fibre® 200mL** *or* **Fortisip Multifibre® 200mL**

If a patient is unable to meet their nutritional requirements through diet alone or is unable to eat, then enteral feeding may be recommended. This may be nasogastric (NG), gastrostomy, e.g. PEG (percutaneous endoscopic gastrostomy), RIG (radiologically inserted gastrostomy) or jejunal feeding. The dietitian will recommend a prescribable feed to meet the patient's nutritional requirements. All adult patients within Lothian on enteral feeds are monitored and reviewed in conjunction with the Community Enteral Nutrition Team (CENT), contact: 0131 537 6052/3. All ancillaries for enteral feeding are non-prescribable products, and the supply of these is co-ordinated by CENT. Refer to 'Lothian Enteral Tube Feeding Best Practice Statement for Adults and Children' [2].

References

1. Managing Drug Users in General Practice. 4th Edition. NHS Lothian. 2003. http://intranet.lothian.scot.nhs.uk/nhslothian/healthcare/clinical_guidance/handbook_on_managing_drug_user.aspx
2. Lothian Enteral Tube Feeding Best Practice Statement for Adults and Children. NHS Lothian. January 2007. http://intranet.lothian.scot.nhs.uk/nhslothian/a_z/d/dietetics/tube_feeding.aspx

Correction

We apologise for the error on page 3 of Lothian Prescribing Bulletin Issue No. 25 - February/March 2007. It should have read "atorvastatin (Lipitor®) 10mg x 28 costs £18.03", and not £10.83 as stated.

Smoking cessation in Lothian - prescribing guidance and outcomes

NHS Lothian's aim is to protect and improve health through working towards creating a smoke-free environment[1]. In Lothian, an estimated 1,500 deaths and 9,000 hospital admissions occur every year as a result of smoking, and NHS Lothian spends £22.6million annually treating diseases caused by smoking[2]. Data from the national electronic smoking cessation database for patients setting quit-dates in 2006 were recently published[3]. In terms of numbers of patients setting quit-dates during the year, there is a downward trend in Lothian, as in other Scottish Health Boards, compared to the previous year. Lothian 3-month quit rates are 8%, the Scottish average is 17%.

Smoking cessation services for those who are ready to stop smoking have been in operation in Lothian since 2000 with almost 18,000 patients having been through the service. Whilst there are some local variations, in general the main format is groups, led by trained and experienced facilitators, which operate in community centres and health centres throughout Edinburgh and Lothian. This is in line with the evidence base as per national Smoking Cessation Guidelines for Scotland[4]. There are also services available specifically to help pregnant women or young people to stop smoking. Increased funding has enabled the appointment of more stop smoking specialist facilitators and has significantly shortened waiting lists. Contact details are available on the NHS Lothian intranet at http://intranet.lothian.scot.nhs.uk/nhslothian/healthcare/a_z/s/stop_smoking_services.aspx.
In addition to the existing post, which is currently based at the Royal Infirmary of Edinburgh (RIE), new posts are being established within the acute hospitals at the Western General Hospital (WGH), RIE and St John's Hospital to offer a service for inpatient smokers. A service will also be offered to cancer patients at the WGH - contact details are not yet available.

Formulary recommendations

The LJF section, 4.10 (h), on smoking cessation was updated recently.

Step 1: smoking cessation support based on assessment of patient's motivation to quit

Step 2: **nicotine replacement therapy (NRT):**
First choice: continuous therapy
(patch) + cessation support
Second choice: intermittent therapy
(lozenges/gum) + cessation support

Step 3: **bupropion** + cessation support

Key prescribing points:

Adolescents

NRT may be prescribed to adolescents (12 to 18 years). Ideally there should also be a referral to a specialist stop smoking service for young people.

Pregnancy

Intermittent NRT is preferred during pregnancy to minimise foetal nicotine exposure. A patch may be appropriate if nausea/vomiting are a problem and, if used, should be removed before going to bed.

Breast Feeding

NRT can be used if breast feeding. Intermittent NRT products are preferred.

Cardiovascular Disease

In patients with stable cardiovascular disease, NRT is a lesser risk than continuing to smoke and is therefore recommended. Dependent smokers with an acute cardiovascular illness, who are in hospital, should be encouraged to stop smoking with non-pharmacological measures. If this fails, NRT may be considered but initiated under medical supervision.

Diabetes

Nicotine releases catecholamines which can affect carbohydrate metabolism. Smokers with diabetes should be advised to monitor the blood sugar levels more closely than usual when attempting to quit (with or without NRT).

Hepatic and Renal Impairment

Moderate to severe hepatic impairment and/or severe renal impairment decreases the clearance of nicotine and its metabolites and NRT should be used with caution.

Varenicline

Varenicline may be an alternative to bupropion as a component of a smoking cessation support programme. Trials show it appears to have fewer drug interactions and contra-indications than bupropion, but the efficacy and safety in patients with significant co-morbidity is unclear. It should be prescribed for a maximum of 12 weeks only.

References

1. No Ifs, No Butts. A Tobacco Strategy for NHS Lothian. 2006-2010. www.nhslothian.scot.nhs.uk/nhsl_tobacco_strategy.pdf
2. Harding, O. Smoking 'Ready Reckoner'. ISD Scotland. Edinburgh. May 2005.
3. ISD Scotland. National statistics. 26 March 2007. www.isdscotland.org/isd/4726.html
4. Smoking cessation guidelines for Scotland. NHS Health Scotland. 2007. www.healthscotland.com/documents/1762.aspx

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