LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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In this issue ...

Show them the yellow card

In May 2006 CSM Scotland, Centre for Adverse Reactions to Drugs (Scotland) became Yellow Card Centre (YCC) Scotland following changes at the Medicines and Healthcare products Regulatory Agency (MHRA). YCC Scotland provides education and training on adverse drug reactions (ADRs) and has an evolving education and training strategy. The centre is happy to arrange talks or continuing professional development sessions.

YCC Scotland reports to Area Drug and Therapeutics Committees throughout Scotland. It compares the Yellow Card reporting profile of health boards in Scotland, which helps to identify trends. Annual reports for Lothian are also available.

Any questions regarding ADR reporting, health board reports or the Yellow Card Scheme can be discussed with a member of the YCC Scotland team:
telephone: 0131 242 2919
email: YCCScotland@luht.scot.nhs.uk.
A slide presentation on ADRs is also available for downloading from www.yccscotland.scot.nhs.uk.

Thanks to Melinda Cuthbert and Sheila Noble, Senior Pharmacists, YCC Scotland, and Sheena Kerr, Lead Pharmacist, Western General Hospital (formerly Principal Pharmacist, YCC Scotland) for contributing to this article.

How common are ADRs?
ADRs are responsible for 6.5% of adult hospital admissions (15% of admissions in the elderly). During a stay in hospital 6.7% of adults experience an ADR, of which 0.3% are fatal.

Who can report ADRs on a Yellow Card?
It is not just doctors and pharmacists that can report ADRs; dentists, coroners, nurses, midwives, health visitors, radiographers, optometrists and members of the public can all complete Yellow Cards. Success of voluntary reporting schemes relies on the willingness of people to continue to report ADRs.

What are the reporting criteria?
All ADRs should be reported for newly marketed (black triangle ▼) drugs and vaccines, herbal products, suspected drug interactions and reactions in children. Serious reactions for established drugs and vaccines should also be reported. Serious reactions are defined as fatal, life threatening, disabling, incapacitating, resulting in prolonged hospital admission, congenital abnormalities and/or otherwise medically significant.

How can ADRs be reported?
- MHRA website www.mhra.gov.uk
- YCC website www.yccscotland.scot.nhs.uk
- Forms at the back of the BNF

Withdrawal of co-proxamol - switch to alternative now

In January 2005 the MHRA announced the gradual withdrawal of co-proxamol from the market, due to concerns surrounding safety (particularly in overdose) and efficacy. The MHRA advised that patients should be switched to alternative analgesics and that no new patients should start co-proxamol therapy. All co-proxamol licences are to be withdrawn at the end of 2007.

Prescribing of co-proxamol in primary care within Lothian has decreased over the last 3 years from approximately 15,000 items for the period April to June 2005 to approximately 3,500 for April to June 2007.

Patients who are currently being prescribed co-proxamol should be switched to an alternative analgesic now.
See LJF section 4.7 - Analgesics, Step 2: mild to moderate pain, www.ljf.scot.nhs.uk.

Drugs used in substance dependence

In Lothian there are over 5,000 patients currently on treatment for drug dependence. Decisions regarding prescribing for drug dependence should only be made after full assessment by an experienced practitioner. Appropriate psychosocial support is an important adjunct to prescribing and significantly improves outcomes.

Acute opioid withdrawal symptoms

It is important that the wish to alleviate the symptoms of opiate withdrawal does not lead to inappropriate treatment decisions. Lofexidine and other symptomatic treatments may be used, but a decision to start substitute opioids must not be made without full assessment. Short term dihydrocodeine may be an option for hospital inpatients suffering acute withdrawal symptoms.

Opioid maintenance prescribing

Methadone remains the first choice treatment. It should only be initiated after full assessment, and in many cases this will involve referral to a specialist service. Supervised consumption is advised until a stable regime is established. Dihydrocodeine continues to have a role, although it is not licensed for this indication. Sublingual buprenorphine or buprenorphine/naloxone may be used as an alternative by specialist services.

Opioid reduction prescribing

This should be carried out when the patient is motivated and ready and should not be imposed. A flexible plan is preferable, with the option to pause the reduction if necessary. Patients should be made aware of the implications of reduced tolerance.

Opioid detoxification

More rapid detoxification requires full assessment and discussion of the risks as well as significant monitoring and psychosocial support. Buprenorphine is now the first choice in preference to lofexidine but is currently recommended for specialist use only. It should be prescribed with daily supervised consumption. A reducing course of dihydrocodeine may be a useful alternative for those unable to access buprenorphine.

Opioid relapse prevention

Naltrexone is an opioid blocker, currently licensed for specialist prescribing only. Liver function tests should be monitored before and during treatment, and patients should carry an emergency medical card. Prescribed or over-the-counter opioids, e.g. for pain control, should be avoided.

Acute benzodiazepine withdrawal symptoms

Planned withdrawal from long term benzodiazepines should usually be carried out gradually. If withdrawal is abrupt, short term treatment with diazepam or carbamazepine may be used to reduce the risk of withdrawal seizures.

Benzodiazepine prescribing

There is increasing evidence of dose-dependant cognitive impairment associated with long term benzodiazepine use. Efforts should be made to minimise the dose and duration of use in most cases, and doses greater than 30mg/day should rarely be used.

In-patient care of drug users (other than for addiction)

Established maintenance treatment should be maintained after confirmation with the prescriber and/or pharmacist. Patients on methadone maintenance will still need pain relief: non-opioid analgesics are preferable but, if opioids are necessary, larger doses than usual may be needed, with appropriate monitoring.

Recommended minimum methadone supervision

Methadone supervision	Minimum duration of supervision
Starting or re-starting methadone	until dose stabilised and for further 2 weeks
Increase dose by 10mg or more	for 2 weeks
All patients on methadone	2 weeks each year (can be done as 2 separate weeks)
Chaotic drug users	until stable
Drug users about whom there are professional concerns	as necessary
By request from drug user	as requested

Thanks to Dr Muriel Simmonte, Primary Care Facilitator, Substance Misuse Directorate, and Amanda Hart, Pharmacist, Community Drug Problem Service, for contributing to this article.

Treatment of hyperprolactinaemia

The first choice treatment in the LJF for hyperprolactinaemia has been amended and is now quinagolide. As a non-ergot preparation it should be free from the side effects associated with ergot-derived dopamine agonists.

6.7.1 Treatment of hyperprolactinaemia	
First choice:	quinagolide
Second choice:	bromocriptine *or* cabergoline

See www.ljf.scot.nhs.uk for full prescribing information.

Following on from the Food and Drug Administration's decision for pergolide to be voluntarily withdrawn from the market in the USA[1,2] (because of the risk of damage to heart valves), the Medicines and Healthcare products Regulatory Agency (MHRA) produced a statement regarding dopamine agonists for Parkinson's disease. In the MHRA statement there were also new restrictions and cautions for the prescribing of cabergoline. The MHRA have indicated in personal communication that these restrictions also apply to the use of cabergoline for hyperprolactinaemia. The UK Summary of Product Characteristics for Dostinex® (licensed brand of cabergoline for the management of endocrine disorders) is currently under review.

References

1. Restrictions on the use of dopamine agonists (pergolide and cabergoline) for Parkinson's disease. MHRA. 28 February 2007. www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2030729
2. Cabergoline: cardiovalvulopathy. MHRA / CHM Drug Safety Update. August 2007. www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2031802&ssTargetNodeId=1100

CPD… look and learn

The LJF as part of its ongoing commitment to support excellent prescribing contains educational modules accredited for Continuing Professional Development (CPD). CPD packs have been prepared for:

- GP prescribers (Gpass and others)
- Hospital doctors and pharmacists
- Community pharmacists and other pharmacists working in primary care

Prescribing is one of the core categories for the GP appraisal scheme. The GP modules are accredited for 3 hours EPASS.

Educational modules can be downloaded from the website www.ljf.scot.nhs.uk. You can test your knowledge, check the answers supplied, and then request the EPASS certificate or CPD Record or Learning Record from the Medicines Management Team.

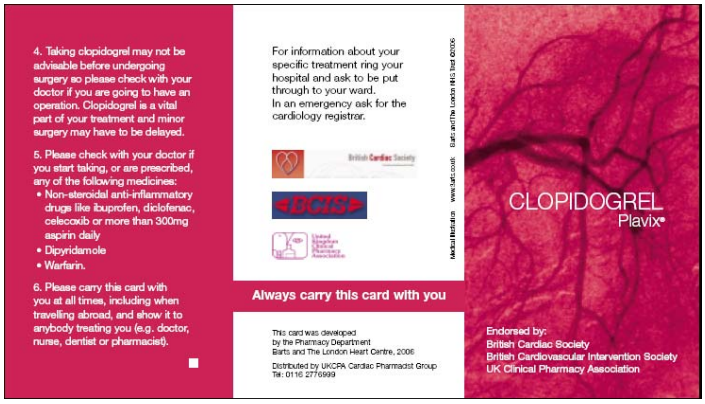
Key message:

CPD Packs are an easy, non-threatening, informative and educational way to fulfil part of your annual CPD requirements.

Clopidogrel guideline

Guidance for the use of clopidogrel has been reviewed and updated to reflect the recent changes in the cardiovascular section of the formulary. **The guideline is included as an insert with this bulletin.** It now includes a treatment flow chart for cardiovascular disease and advice on treating patients with significant GI upset due to aspirin and peptic ulcer disease. It is recommended that patients will be provided with a clopidogrel card on discharge from hospital, which will include details of indication and planned duration of treatment.

For a sample clopidogrel card, see the UK Clinical Pharmacy Association website www.ukcpa.org/?pid=0&lsid=3593&edname=22554.htm&ped=22554



Immunisation update

Influenza Immunisation Programme 2007/2008
The full list of clinical risk groups is detailed in an NHS letter[1]. The following new groups have been added to the clinical risk groups to be offered vaccination:

- Patients with diabetes who control their diabetes with diet alone. This is in addition to patients with diabetes who require insulin or oral hypoglycaemic drugs.
- Individuals with the following neurological conditions: cerebrovascular disease (principally stroke and transient ischaemic attacks); multiple sclerosis and related conditions; hereditary and degenerative disease of the central nervous system.

Further information has been issued by the Scottish Government on publicity materials, payment arrangements and adverse reaction reporting[2].

References

1. Influenza Immunisation Programme 2007/2008. CMO(2007)4. Scottish Executive Health Department. 30 March 2007. www.sehd.scot.nhs.uk/cmo/CMO(2007)04.pdf
2. Influenza and Pneumococcal Immunisation Programme 2007-08. CMO(2007)8. Scottish Executive Health Department. 11 September 2007. www.sehd.scot.nhs.uk/cmo/CMO(2007)08.pdf

Professor Duncan Jodrell, Professor of Cancer Therapeutics, University of Edinburgh, has provided the following **additional advice on vaccination for cancer patients:**

Influenza vaccination should be offered to all cancer patients with solid tumours who are 65 years or over (or in a high-risk group, as for general vaccination advice). Patients having chemotherapy should be advised to arrange vaccination with their GP, and the GP should be informed by letter. Ideally this should be at least 2 weeks before the start of chemotherapy but, if this is not possible, patients can still be vaccinated during a course of chemotherapy, although there is a possibility that response may be sub-optimal. Vaccination needs to be repeated annually.

Pneumococcal vaccination should be offered to all cancer patients with solid tumours who are 65 years or over (or in a high-risk group, as for general vaccination advice). Ideally, vaccination should be given 4 to 6 weeks prior to chemotherapy but, if this has not been possible, at least 2 weeks before. If vaccination has not taken place prior to chemotherapy, the recommendation is that vaccination should be delayed until 3 months after immunosuppressive chemotherapy. It can be given at the same time as the influenza vaccine. The vaccine is given once only, except in asplenic patients and those with nephrotic syndrome who should be revaccinated every 5 to 10 years.

Prescribing Indicator graphs - have you seen them?

Prescribing Indicator (PI) attainment graphs are now being emailed quarterly to practice managers for each general practice in Lothian. Paper copies will no longer be posted. These graphs indicate your practice's PI performance compared to all other practices in Lothian. Ask your practice manager for a copy.

Enclosed with this Issue:

- **LJF Calendar 2008**
- **Clopidogrel guidelines**

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