LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 34

August / September 2008

In this issue …

Wound management products – remember the formulary!

Expenditure in NHS Lothian on wound management products has increased by 18% from 2006/07 to 2007/08. This increase is the equivalent of £450,000, taking expenditure to £3 million. This percentage increase is second only to the rise in respiratory prescribing. The increase is not due to the number of items prescribed or to increases in the individual unit cost of products, therefore it must be due to more expensive products being prescribed.

The Lothian Joint Formulary (LJF) provides advice to promote cost effective, evidence based prescribing. The wound section of the LJF was launched in 2006.

As well as providing advice on first and second choice products (aiming to cover 80% of patients) it also provides advice on how the products should be used and when alternatives may be required.

Work continues to promote the LJF and to ensure that all practitioners involved in managing wounds can access the appropriate education support.

There is a Lothian prescribing indicator focusing on wound dressings and work is ongoing to further refine this measure.

Focus on Foam dressings

First choice

with adhesive border **Allevyn® Adhesive**

without adhesive border **Tegaderm Foam®** (previously called 3M®)

Second choice

with adhesive border **Tegaderm Foam® Adhesive** (previously called 3M®)

without adhesive border **Allevyn®**

Expenditure for first and second choice products for the last quarter in 2007/08 was £101,299 compared with £89,575 for all other products. Compliance to the LJF for wound dressings was recently measured at 53%. Of the 47% non-formulary prescribing, one product in particular (Mepilex®), is being prescribed more than any other. Mepilex® may be prescribed for patients with delicate or fragile skin, painful wounds and or wounds that are difficult to dress. It is mentioned in the 'notes' section of the formulary but is not first or second choice. However, it accounts for nearly half of the overall expenditure on foam dressings.

Mepilex® should be used as an exception. Practices should review their use of this product and ensure that its use is appropriate. For example it may not be appropriate to keep Mepilex® as stock in the treatment room.

Managing adults with acute psychosis

Acute psychosis presents *"in a variety of ways and may be the result of numerous aetiologies. Treatment may be deferred in some individuals while an initial assessment is being completed, although many patients require immediate pharmacotherapy. A balanced approach to the management of acute psychosis must take into consideration such factors as symptomatology, choice of medication and its formulation, management of adverse effects and longer term treatment goals".*[1]

The Lothian Joint Formulary (LJF) recommendations on the use of antipsychotic medicines were updated recently, in particular the recommendations for treating acute psychosis were significantly amended.

Adult patients (18 to 65 years old)

The choice of antipsychotic used to treat acute psychoses in adults depends on a number of factors, including patient choice, previous response, first episode psychosis, possible side effects, and concordance. Hyperglycaemia has been reported in patients prescribed atypical antipsychotics. It is recommended that all patients receiving atypical antipsychotics, particularly olanzapine[2] should be monitored for symptoms of hyperglycaemia. Shared care protocols are available for the use of antipsychotic drugs in the treatment of schizophrenia, and include useful prescribing information - see the LJF website at www.ljf.scot.nhs.uk/scp/index.html.

4.2.1 (a) Treatment of acute psychoses
(primary and secondary care)

First choice: **chlorpromazine**
Second choices: **risperidone**
or **olanzapine**

4.2.1 (b) **Rapid control of agitation and aggression**
(secondary care)

First choice: **haloperidol *AND* lorazepam**
Second choice: **olanzapine**
NB do not administer intramuscular olanzapine with a benzodiazepine

Please refer to the good practice guideline '*Drug Treatment of Acute Behavioural Disturbance in General Adult (18-65 years) Psychiatric In-Patients*', available on the NHS Lothian intranet at http://intranet.lothian.scot.nhs.uk/nhslothian/healthcare/clinical_guidance/lothian_guidelines.aspx

Older patients (> 65 years)

Antipsychotics are frequently prescribed in the management of behavioural disorders associated with dementia. Other forms of management should also be considered before prescribing antipsychotics. Such behaviour can be a temporary phenomenon, and drugs should be prescribed on a short-term basis.

In the elderly, antipsychotics should be used with caution due to increased sensitivity to side effects, such as extra pyramidal symptoms, sedation, anticholinergic effects, cardiovascular effects (in particular stroke) and tardive dyskinesia.

It is desirable that doses of all antipsychotics should be kept as low as possible and reviewed on a regular basis. SIGN recommends that antipsychotic withdrawal should be considered in patients who are stable.[3]

4.2.1 (c) Antipsychotics for older patients
(primary and secondary care)

First choices: **amisulpride**
quetiapine

References

1. Remington GJ, Bezchlibnyk-Butler K. *Current Concepts in the Pharmacotherapy of Acute Psychosis*. CNS Drugs. Aids International. 1998;*9(3)*:191-202. www.ingentaconnect.com/content/adis/cns/1998/00000009/00000003/art00003
2. Taylor D, Paton C, Kerwin R. The Maudsley Prescribing Guidelines. Informal Healthcare. 9th edition. 2007.
3. Management of patients with dementia. Scottish Intercollegiate Guidelines Network. February 2006. www.sign.ac.uk/pdf/sign86.pdf

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

Thanks to Mrs Ruta Nicol, Principal Clinical Pharmacist, Royal Edinburgh Hospital and Dr Bill Riddle, Consultant in Psychiatry, for commenting on this article.

Contraceptives – important new changes

The LJF section on contraceptives has recently been updated – the key changes are detailed here:

- Prescribe co-cyprindiol 2000/35 by generic name rather than Dianette®, as there are a number of brands now available
- Orthocreme® and Orthoforms® have both been discontinued. Gygel® is the only alternative and has been added to the LJF
- NHS Quality Improvement Scotland, Standards for Sexual Health Services (March 2008) include a recommendation that the uptake of IUD/IUS and implants should be increased in women requiring contraception
- Recent evidence reported suggests there is no benefit of the transdermal route for combined oral contraceptive (COC) in terms of reducing the risk of venous thromboembolism
- There is no need to use a double dose of progestogen-only pill (POP) in women over 70kg

Prescribing costs

- **There are approximately 26 different brands of COC available and 5 different brands of POP. Note: costs of the preparations vary over time.**
- **LJF choices only account for 71% of the total expenditure on oral contraceptives**
- **Ovranette® is currently less expensive than Microgynon 30® (no longer a formulary choice) and they are the same composition, therefore new patients should be started on Ovranette®**
- **The addition of Katya 30/75® to replace Femodene® as a second choice combined oral contraceptive. They are equivalent but Katya 30/75® is a lower cost**
- **Cerazette®, LJF second choice POP, is substantially more expensive than the other POPs and is prescribed more than the three other LJF choices added together.**

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

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'The Bottom Line' No. 3 - Glucosamine for osteoarthritis

Some patients take glucosamine tablets believing that it helps their arthritis but doctors have been reluctant to provide an NHS prescription because the clinical evidence for any benefit has been lacking. Do we now have an answer? The preparation, glucosamine hydrochloride (Alateris®) is the first licensed form of glucosamine in the UK. The Scottish Medicines Consortium (SMC) has recently reviewed the clinical and cost effectiveness of this product and issued the following advice:

- Glucosamine (as hydrochloride) (Alteris®) is not recommended for use within NHS Scotland for relief of symptoms in mild to moderate osteoarthritis of the knee
- No direct clinical trial evidence of the efficacy and safety of this specific product are available. Randomised control trials of other formulations of glucosamine hydrochloride indicate little or no benefit over placebo in improving symptoms in patients with osteoarthritis of the knee

In addition, the manufacturer did not present a sufficiently robust economic analysis to gain acceptance by SMC.

The Bottom Line:

- SMC advises that glucosamine hydrochloride (Alanteris®) is **not recommended** for use within NHS Scotland

Reference SMC Report No. 471/08. 9 June 2008. www.scottishmedicines.org.uk

Safe prescribing and dispensing of methadone

Lothian Substance Misuse Services wish to remind prescribers and pharmacists of the various issues relating to the safe use of methadone. Methadone should normally be prescribed **1mg in 1mL oral solution** for drug misusers. Prescribers must specify if they require the **sugar-free** formulation. Methadone oral solution 1mg/mL is typically **green** though there are colour-free products. The green colour is important as it makes it easy to identify and difficult to mistake for anything else - which helps prevent accidental overdose.

UK Guidelines advise that colour-free or higher-strength methadone oral solution is not recommended for routine use[1]. Therefore, if other formulations or strengths are prescribed, steps must be taken to ensure that this is clinically appropriate for the individual patient, and steps are taken to minimise risk, for instance recommending supervised consumption. Pharmacists are reminded of the importance of dispensing exactly what the prescription specifies when dealing with methadone prescriptions. Sugar-free and colourless preparations may only be dispensed if specifically prescribed.

Dispensing interval and volumes

The prescriber will specify dispensing arrangements after assessment of the individual patient taking into account the patient's dose, stability and personal circumstances, including the ability to ensure safe storage. This will be influenced by feedback from other professionals, including the community pharmacist, in regular contact with the patient.

- Methadone should usually be dispensed between daily and weekly[2]
- In general, it is accepted good practice that volumes of methadone supplied in a single supply for 'take home' doses should not exceed 350mL[3]; it should be unusual for any patient to receive a dispensed volume of more than 350mL (1mg/1mL), at a time other than in special circumstances[2] (the average dispensing volume of methadone from GP practices in Lothian providing the NES for drug misusers is currently 200mL)
- Exceptions to this should be made only where the prescriber is satisfied that the drug user is stable and can manage a larger supply without danger to themselves or others.

References

1. Department of Health (England) and the devolved administrations (2007). Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.
2. Local AIDS Sheet. Safer Prescribing. Primary Care Facilitator Team, NHS Lothian Substance Misuse Directorate, Number 105, September 2006. http://intranet.lothian.scot.nhs.uk/nhslothian/healthcare/useful_resources/local_aids_sheets.aspx
3. NHS Lothian Guidelines for Dispensing and Supervised Self Administration of Methadone by Community Pharmacists. 3rd edition. November 2007. [distribution pending]

Thanks to Elaine Rankine, Specialist Pharmacist in Substance Misuse and Dr Muriel Simmonte, Primary Care Facilitator, Substance Misuse Directorate, for contributing to this article.

Do quality incentives change prescribing patterns?

A prescribing analysis of 92 of the 100 GMS practices in Lothian was carried out to determine the impact of the 2004 GMS contract on general practice prescribing. The change in the prescribing of medicines was measured over a 4 year period (2 years prior to the introduction of the contract and 2 years after). Two groups of medicines were included, the first, those directly or indirectly affected by the Quality Outcomes Framework (QOF) (e.g. statins, beta-blockers, insulin); these were termed QOF drugs. The second group were all the other medicines listed in the first 10 chapters of the BNF and these were termed non-QOF drugs.

The analysis showed that the rate of growth of QOF drugs was significantly higher than the non-QOF drugs before and after the introduction of the contract. Interestingly, the growth of QOF drugs was significantly lower after the introduction of the contract. **It would appear that substantial work was undertaken by the practices in preparation for the introduction of the contract, which helps to explain the higher than expected attainment of QOF in the first year. The group of drugs that had the highest growth over the 4 year period was the statins.**

Reference

MacBride-Stewart SP, Elton R and Walley T. Do quality incentives change prescribing patterns in Primary Care? An observational study in Scotland. Family Practice 2008;*25*:27-32. www.ncbi.nlm.nih.gov/pubmed/18245796

Thanks to Sean MacBride-Stewart, Primary Care Pharmacist in NHS Lothian for contributing this article.

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View the Lothian Joint Formulary at www.ljf.scot.nhs.uk