LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 50

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In this issue …

Welcome to the 50th issue of the LPB!

'The Bottom Line No.8'
Aspirin - *not recommended* for primary prevention of cardiovascular disease

Aspirin is no longer recommended for the primary prevention of cardiovascular events as the risks of treatment are greater than the benefits, even in high risk patients. The evidence for the recommendation is based on two good quality randomised controlled trials, AAA (Aspirin for Asymptomatic Atherosclerosis)[1] and POPADAD (Prevention Of Progression of Arterial Disease And Diabetes)[2].

The results of these studies are supported by three recent meta-analyses. Of these, the Cochrane review[3] demonstrates clearly that in hypertensive patients on aspirin, although there is a small reduction in MI (NNT 200 for 5 years), this is offset by the increase in major haemorrhage (NNT 154 for 5 years).

It will take some time for national guidelines to catch up with the evidence. SIGN 116 states that: 'Low-dose aspirin is not recommended for primary prevention of vascular disease in patients with diabetes'.[4]

Key message:

Aspirin is no longer recommended for primary prevention of cardiovascular disease, even in high risk patients.

Salix alba

The MHRA issued a *Drug Safety Update* in October 2009, stating: "The results of these recent studies lend support to the licensed indications for aspirin in secondary prevention of vascular events only. Aspirin is not licensed for the primary prevention of vascular events."[5]

Prescribers should consider reviewing all patients (**not** in AF) taking aspirin 75mg for the primary prevention of cardiovascular events, including those with hypertension, diabetes, and those with a cardiovascular risk score of ≥20% over 10 years, with a view to stopping treatment. This is also an opportunity to review the use of PPIs in these patients.

References

1. Fowkes FG *et al.* Aspirin for prevention of cardiovascular events in a general population screened for a low ankle brachial index: a randomized controlled trial. JAMA 2010;*303*:841-8.
2. Belch J *et al.* The prevention of progression of arterial disease and diabetes trial: Br Med J 2008;*337*:a1840.
3. Lip GYH, Felmeden DC. Antiplatelet agents and anticoagulants for hypertension. Cochrane Database of Systematic Reviews 2004, Issue 3. Edited (no change to conclusions), published in Issue 4, 2008.
4. Management of diabetes. Guideline 116. Scottish Intercollegiate Guidelines Network. NHS Quality Improvement Scotland. March 2010. www.sign.ac.uk
5. Aspirin: not licensed for primary prevention of thrombotic vascular disease. Drug Safety Update. MHRA. October 2009. www.mhra.gov.uk.

Ag… Silver dressings - use judiciously!

Silver dressings often can be identified by the words 'Silver' or 'Ag' in the product name. They are classed as 'advanced' dressings and were developed primarily for difficult-to-heal wounds, chronic ulcers and extensive burns.[1]

The use of silver dressings has increased rapidly in recent years. Silver dressings are expensive and there have been few high quality clinical trials to establish whether they have advantages over other, cheaper alternatives.

Most studies undertaken have methodological limitations. With these factors in mind the routine use of silver dressings (in non-infected wounds) is not justified on clinical or cost-effectiveness grounds.[2]

In 2010-11 NHS Lothian primary care spent approximately £600,000 on silver dressings, accounting for 16 per cent of the expenditure on all wound management products. This is a 10 per cent increase on the previous year's spend, compared with reductions seen in other Scottish Health Boards.

Dressing choice depends on the type and stage of the wound, and cost should be considered. Where silver dressings are used, the wound should be reassessed regularly (within two weeks). Silver dressings should be stopped if the wound does not respond (should not exceed four weeks), or once infection is controlled.

Overall, the amount currently spent in the NHS on silver dressings appears difficult to justify in the light of the existing data.

LJF Choices

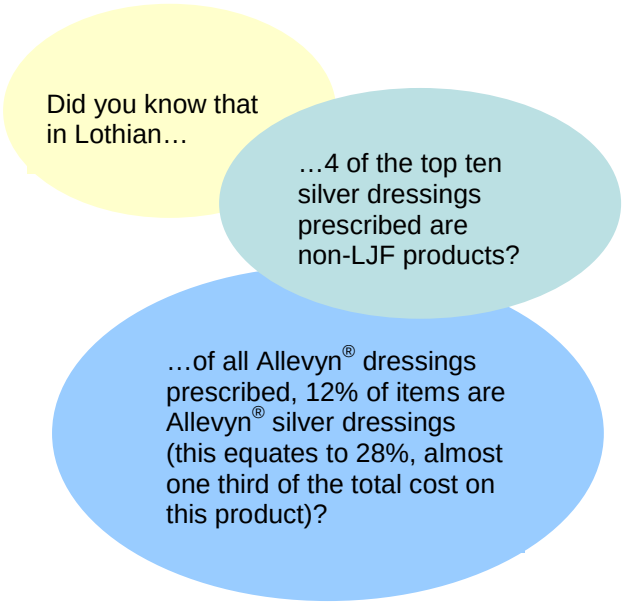
Absorbent/fibrous
First choice: **Aquacel® Ag**

Second choice: **Acticoat® Absorbent**

Silver releasing sheet
First choice: **Acticoat® / Acticoat® 7**

Silver ointment
First choice: **Flamazine® (silver sulfadiazine 1.0% w/w)**

Silver Foam
First Choice: **Allevyn® Ag** (without adhesive border)
Second Choice: **Mepilex® Ag**



Key messages:

- **Routine use of silver dressings is not justified on clinical or cost-effectiveness grounds**
- **Use Lothian Joint Formulary product choices**
- **Reassess wounds regularly.**

References

1. Evidence-based prescribing of advanced wound dressings for chronic wounds in primary care. MeReC Bulletin 2010;*21(1)*:1-7. www.npc.nhs.uk/merec/therap/wound/resources/merec_bulletin_vol21_no1.pdf
2. Silver dressings – do they work? Drug & Therapeutics Bulletin 2010;*48(4)*:38-42.

Take Home Naloxone programme: an intervention to reduce drug-related death

What is it?

The Scottish Government has announced the roll out of Take Home Naloxone (THN) across Scotland, following a number of successful pilots. The aim of THN is to reduce the number of fatal opiate overdoses in Scotland. The Take Home Naloxone Programme involves supply from a Patient Group Directive (PGD).

How will it work?

The Lothian THN Team has been developed in partnership with relevant local agencies. The programme will be delivered by appropriately trained Harm Reduction Team nurses. The nurses will provide patients (or their representative) deemed at risk of opiate overdose, training in overdose prevention, basic life support and injecting naloxone. They will also be provided with a naloxone kit and written support materials. The programme will start during April 2011 and will initially be targeted to those patients at highest risk including those attending drug services for injecting equipment. CDPS will not be the only site; this will also involve locality drug clinics and the Harm Reduction Team, Spittal Street Centre and outreach work. If you would like further information, please contact:

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Thanks to Elaine Rankine, Substance Misuse Pharmacist, for contributing to this article.

Budesonide (Pulmicort®) CFC-free inhalers - discontinued

Production of Pulmicort® CFC-free inhalers (budesonide 100 micrograms and 200 micrograms) has been discontinued. The Nebuchamber® Spacer device for use with Pulmicort® has also been discontinued. Patients should be advised that they may continue using Pulmicort® CFC-free inhalers until their current supply is finished, but will then require to be switched to an alternative product. The Lothian Joint Formulary inhaled corticosteroid of choice is Clenil Modulite® (beclometasone MDI).

Clinicians should be aware that alternative inhaled corticosteroids and devices may not result in the equivalent clinical effect in individual patients. Therefore, patients should be monitored for deterioration in their respiratory condition after switching. Dose adjustment of the new preparation may be required in order to maintain an equivalent response. Clinical teams should take the opportunity to reassess patients' inhaler technique and choose a device that most suits each individual patient.

Key messages:

- **Switch patients to equivalent beclometasone MDI product (Clenil Modulite®) and check the patient's inhaler technique**
- **Monitor the patient's symptoms after switch and review.**

Thanks to Douglas McCabe and Jenny Scott, Clinical Pharmacists for contributing to this article.

Prucalopride - *not recommended* for symptomatic treatment of chronic constipation in women

The Scottish Medicines Consortium (SMC) has advised that prucalopride (Resolor®) is not recommended for use within NHS Scotland for the symptomatic treatment of chronic constipation in women in whom laxatives fail to provide adequate relief.[1] In December 2010, the National Institute for Clinical Excellence (NICE) performed a single technology appraisal (STA)[2] of prucalopride and recommended it for use within England. NICE STA recommendations have no formal status in Scotland and NHS boards should continue to adhere to SMC advice. Any requests for prucalopride will be considered on a 'case by case' basis via the Individual Patient Treatment Request (IPTR) Panel, formerly known as the Exceptional Cases Panel. Until a positive opinion is issued by the SMC, prucalopride should not be prescribed. Advice following a resubmission is expected to be issued in July 2011, but at this stage it is not possible to guess the outcome.

References

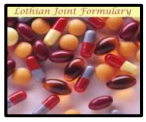
1. Prucalopride 1mg and 2mg tablet (Resolor®). Scottish Medicines Consortium advice. SMC No. 653/10. November 2010. www.scottishmedicines.org.uk/SMC_Advice/Advice/653_10_prucalopride_Resolor/prucalopride_Resolor
2. Prucalopride for the treatment of chronic constipation in women. NICE technology appraisal guidance 211. December 2010.

Thanks to Joanna C Skwarski, Senior Pharmacist, Clinical Trials, Gastrointestinal Medicine, for contributing to this article.

The Lothian Joint Formulary - electronic prescribing

eLJF-CLINICAL

Formulary Headings



BNF01 Gastrointestinal	BNF07 O&G and urinary
/COLItis	/CONTraception
/CONStipation	/DYSMenorrhoea
/DANDV	/ENDOmetriosis
/DYSPepsia	/IRREgular period
/GI	/LICHen sclerosis
/HPYLori	/INCOntinence
/PILEs	/IMPOtence
	/MENOrrhagia
BNF02 Cardiovascular	/PCOS
/ARRHythmia	/PMT
/BP	/PROState hypertophy
/CHD	/VAGInal atrophy
/DVT	
/HEARt failure	BNF08 Malignancy and immunosuppression
/STROke	/IMMUnosuppressant
/WARFarin	/BREAst cancer
BNF03 Respiratory	/SEX hormones
/ALLErgy	/SOMAtostatin
/ANAPhylaxis	/PROState cancer
/ASTHma	
/COPD	BNF09 Nutrition & blood
/MUCOlytic	/BLOOd
/URTIcaria	/CALCium
	/NUTRition
BNF04 CNS	/POTAssium
/ALCOhol	/VITAmin
/ANALgesia	
/ANTIemetic	BNF10 Musculoskeletal
/ANXIety	/GOUT
/BIPOlar	/MULTiple sclerosis
/DEMEntia	/MUSCle relaxant
/DEPRession	/MYASthenia
/DRUGmaintenance	/NSAId
/DRUGwithdrawal	/POLYmyalgia
/EPILepsy	/RHEUmatoid arthritis
/HEADache	
/INSOmnia	BNF11 Eye
/LABYrinthine	/GLAUcoma
/OBESity	/INFEction
/PARKinsonism	/EYE
/PSYChosis	/TEARs
/SMOKing	UVEItis
BNF05 Infection	BNF12 ENT
/CHICken pox	/APHThous
/DENTal	/DRY mouth
/EYE	/EAR
/GASTro-intestinal	/MOUTh ulcer
/GENItal	/NASAl
/ORAL	
/RESPlower	BNF13 Skin
/RESPupper	/ACNE
/SKIN	/ACTInic
/UTI	/ANTIpruritics
	/BARRier
BNF06 Endocrine	/ECZEma
/DIABetes	/EMOLlient
/ENDOcrine	/LICE
/HRT	/PSORiasis
/OSTEoporosis	/ROSAcea
/THYRoid	/SCABies
	/SCALp
	/SOAP
	/SUNscreen

MMT, NHS Lothian Version 1

eLJF-CLINICAL for Vision

Phase 3 of developing an electronic version of the Lothian Joint Formulary (LJF) for use in Vision software, is nearing completion. This is a guideline for Vision that mimics eLJF-GPASS as closely as possible.

The guideline is called eLJF-CLINICAL and will exist as an identifiable 'tab' within Vision's consultation manager. Formulary drugs are located under 'disease' or 'clinical' headings (see Formulary Headings illustration). The headings were derived from the list successfully developed for the GPASS version. However there are some key differences. The list is shorter to minimise the existence of the same drug under multiple headings, which will make the update process safer. Clinical headings can now be identified under BNF chapters. There has been considerable development effort matching the headings list with the current version of the LJF.

The key similarity with eLJF-GPASS is that clinical headings and their associated list of drugs can be located by typing the first 5 letters of the heading. For example, to find the list of drugs to treat for *Helicobacter pylori* infection you type '/hpyl'. The prefix '/' needs to be used to prevent accessing the wrong guideline. This search function is performed within the 'find guideline' 'mnemonic' function. Don't worry about the detail of how to do this as full guidance will be released when eLJF-CLINICAL is implemented.

It is important to realise that this is not a definitive list of all LJF drugs, but aims to include those commonly used in primary care clinical practice.

The guideline is currently being tested by a handful of practices. As long as this goes according to plan it should be available for release sometime in May 2011. eLJF-CHILDREN, eLJF-WOUND and eLJF-PALLIATIVE are still to be developed.

Although the Medicines Management Team has developed eLJF-CLINICAL in a short space of time we are aware of how patient GPs have been in waiting for its release. It is designed to be a workable electronic version of the LJF.

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