LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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LJF update – Respiratory Chapter

Chapter 3 of the LJF has been reviewed and amended. The main changes are described below, please view the LJF website to see all the changes.

Long acting antimuscarinic bronchodilators for COPD

Until recently the only available long acting muscarinic antagonist (LAMA) has been tiotropium. Two new LAMAs, aclidinium and glycopyrronium, have recently been introduced into the market and both have been assessed by the SMC as being suitable for prescribing in NHS Scotland for COPD. Following applications to Formulary Committee, both have been included in the LJF. Both have been assessed to be as clinically effective as tiotropium and they have advantages over tiotropium with regards to device and cost. No significant safety issues have been identifed.

New COPD patients should be initiated on the first choice product after checking that it is appropriate for that patient, however patients who are currently well controlled on tiotropium do not need to be switched.

As with any inhaler device, health care professionals should confirm that the patient can use the inhaler device and this is especially important at reviews and when any changes or additions to therapy are made.

aclidinium (Eklira Genuair®)

LJF 1st Choice LAMA

- Is first choice in the LJF
- The inhaler device is the Genuair®, a preloaded multi-dose device. It has low respiratory resistance and 'sight' and 'sound' feedback to the patient that the dose has been taken
- It is easy to use, even for patients with dexterity difficulties.

glycopyrronium (Seebri Breezhaler®)

LJF joint 2nd Choice LAMA

- Is joint second choice in the LJF with tiotropium
- The inhaler device Breezhaler® requires single capsule loading (but is easier than tiotropium HandiHaler®). It has low respiratory resistance.

Seretide®

LPB Issue 57, September 2012, included an article on the Safe Prescribing of Seretide®.
Significant issues continue regarding the dosing differences between devices. The dosing for the Accuhaler® and Evohaler® are different. Patients should **never** be prescribed 2 blisters (or 2 puffs) of any strength of the Seretide Accuhaler®. This is over the recommended dose of salmeterol.

Easyhaler® – dry powder inhaler device of choice

If a dry powder inhaler is required, the Easyhaler® device should be prescribed. A wide range of drugs are available in an Easyhaler® device (beclometasone, salbutamol, formoterol or budesonide) and it is cost-effective. This simplifies patient education and may also improve compliance.

MDIs remain the recommended first choice device, but it is acknowledged that some patients have difficulties with using these.

Nebulisers

Prescribing notes have been amended to remind prescribers that nebuliser devices should be supplied by secondary care following assessment. If patients buy their own nebuliser, there may be issues with servicing and maintenance that lead to the device functioning incorrectly. Nebulisers are not prescribable in general practice.

Oxygen

The LJF section on oxygen has been removed; instead prescribers are now directed to the NHS Lothian Intranet Respiratory Managed Clinical Network for advice on domiciliary oxygen therapy.

Wound Formulary

Silver dressings – now non-formulary

Scottish Health Technologies Group on behalf of Healthcare Improvement Scotland (HIS) carried out a scoping report following an enquiry from NHS Lothian. This report examined the quantity and quality of published evidence looking at both cost and clinical effectiveness for silver dressings. It was published in January 2013. '*Are silver dressings clinically effective and cost-effective for the healing of infected wounds and the prevention of wound infection relative to other types of dressing?*'

The HIS report stated that:

- There is insufficient clinical evidence to determine if silver dressings achieve complete wound healing or prevent wound infection compared to non-silver dressings.
- No evidence was found relating to the cost effectiveness of silver dressings for either the healing of infected wounds or prevention of wound infection.
- Due to a lack of clinical and cost effectiveness, their use should only be supported by local research and audit examining robust endpoints.

Lothian Advice:

- **Silver dressings have been removed from the Lothian Joint Formulary. The LJF website has been updated.**
- **Guidance to support the implementation of this change and the management of infected wounds will be distributed soon.**
- **A learnPro® NHS module has been developed to support the management of infected wounds.**
- **A non-formulary form is to be completed by the healthcare professional managing the wound when silver dressings are ordered or prescribed in both primary and secondary care. The current form has been amended to better suit dressing requests.**

Other amendments to the wound formulary

Section (d) (ii) Hydrocolloid

Versiva® XC™ was added to the formulary in December 2010 as a cost-effective alternative to the combination of Aquacel® dressing and a foam dressing. However, usage has remained low, and nurses have reported that they are not using the dressing because it can initially increase exudate levels due to the occlusiveness of the hydrocolloid backing. A new dressing, Aquacel® Foam, has been developed that addresses this issue. Instead of a hydrocolloid backing it has a foam backing.

- Aquacel® Foam has a Moisture Vapour Transmission Rate similar to other foam dressings. This enables moisture and exudate balance, increasing wear time and reducing dressing changes. It is not appropriate for wounds with no exudate.
- It can be used as a primary dressing alone to manage shallow wounds or as a secondary dressing for wounds of any depth used in conjunction with other primary dressings.

Section (i) High absorbency dressings

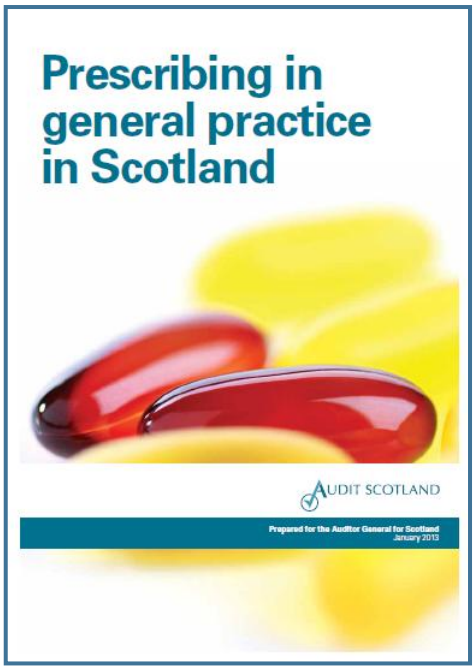
KerraMax® has changed to KerraMax® Care. It now has a lateral wicking layer which spreads exudate and provides an overall higher absorbency.

The properties (for example its thinness) of the original KerraMax® have been retained. It can be layered and used under mild to moderate compression.

Audit Scotland Report
Management of GP prescribing has improved

"The NHS has improved its management of prescribing in general practice". This may seem a rather sweeping statement however it is the fundamental message from the recently published Audit Scotland report.[1]

The audit, which builds on earlier Audit Scotland reports published in 1999 and 2003, was produced following detailed analyses of prescribing data and trends across GP practices, NHS boards and other parts of the UK. Interviews were conducted within four NHS boards (Borders, Fife, Greater Glasgow and Clyde and Highland) to examine how they manage prescribing and engage with stakeholders at a national level, including Scottish Government, Scottish Medicines Consortium, the Royal College of General Practitioners and the British Medical Association.



The report is widely heralded as an excellent news story for general practice and particularly NHS Lothian where comparison of spend per weighted head of population by NHS board demonstrates expenditure well below the Scottish average and second only to NHS Greater Glasgow and Clyde. NHS Lothian's outstanding position was further highlighted particularly in light of the fact that it is the only low cost board with low levels of prescribing support in terms of whole-time equivalent staff per 100,000 population. NHS Lothian further demonstrated its commitment to evidence-based, cost-effective prescribing in the analysis of prescribing of drugs classified as less suitable for prescribing (2011/12) where it had the lowest level of prescribing of all NHS boards.

The report states *"there is scope for the NHS to make potential annual savings of up to £26 million without affecting patient care. NHS boards can achieve this by reducing unnecessary waste; reducing the use of drugs considered less suitable for prescribing; increasing generic prescribing; and only prescribing more expensive versions of drugs to those patients with a clinical need for them."*

Further local analysis is being undertaken by a short life working group to establish what proportion of the reported £26 million of potential savings could be realistically attributed to NHS Lothian given the high calibre of prescribing that has been maintained by the GP community over many years. It should be noted that this figure does not include any replacement drug costs that would be incurred by switching to less costly alternatives.

Work continues within the Primary Care Pharmacy Team and Medicines Management Team to optimise Lothian Joint Formulary adherence, Prescribing Indicator and National Therapeutic Indicator attainment and reduce unnecessary waste through initiatives such as non-clinical medication review training for practice staff and review of repeat prescribing processes.

Key messages from the Audit Scotland Report:

- **Spending on drugs fell by 11% in real terms from 2003/04 to 2011/12 while the quantity of drugs prescribed increased by 33%.**
- **There is scope to make *potential* annual savings of £26 million in NHS Scotland without affecting patient care by reducing unnecessary waste, reducing use of drugs less suitable for prescribing and increasing generic prescribing rates.**
- **Patient age and deprivation have a significant effect on prescribing with practices in the most deprived areas prescribing on average 46% more drugs.**

Reference:

1. Prescribing in general practice in Scotland. Audit Scotland. January 2013. www.audit-scotland.gov.uk/media/article.php?id=226 [Accessed 19/04/13]

Safe use of topical corticosteroids in adults with psoriasis

Lothian Joint Formulary section 13.5.2: *preparations for psoriasis* has been updated to reflect NICE Clinical Guideline 153: *The assessment and management of psoriasis* (October 2012)[1]. This guidance gives clear advice on the safe and appropriate use of topical corticosteroids.

NICE recommendations on safe prescribing of topical corticosteroids in psoriasis[1]:

- Do not use ***very potent*** corticosteroids continuously at any site for longer than 4 weeks
- Do not use ***potent*** corticosteroids continuously at any site for longer than 8 weeks
- Do not use ***very potent*** corticosteroids in children and young people
- Aim for a break of 4 weeks between courses of treatment with potent or very potent topical corticosteroids. Consider topical treatments that are not steroid-based (such as vitamin D analogues or coal tar) as needed to maintain psoriasis disease control during this period
- Arrange a review 4 weeks after initiation to evaluate tolerability, toxicity, and initial response to treatment, and to reinforce the importance of a 4-week break between courses of potent/very potent corticosteroids
- Be aware that continuous use of potent or very potent topical corticosteroids may cause:
    - irreversible skin atrophy and striae
    - psoriasis to become unstable
    - systemic side-effects when applied continuously to extensive psoriasis (for example, more than 10% of body surface area).
- Offer a review at least annually to adults with psoriasis who are using intermittent or short-term courses of a potent or very potent corticosteroid (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

The Primary Care Pharmacy Team has compiled a protocol to support the review of patients prescribed Dovobet® in general practice. This review may be undertaken as a GMS Med 6/10 prescribing action for 2013-14.

The combination product Dovobet® (betamethasone dipropionate 0.05%, calcipotriol 50micrograms/mL), a ***potent*** corticosteroid, is widely used in Lothian. A small pilot study in Lothian indicated that some patients with psoriasis may be using potent corticosteroids in large amounts or continuously, raising concerns over adverse effects and patient safety. Better awareness of the need for short courses of potent corticosteroids interspersed with maintenance treatments that are not steroid based will result in improved patient safety.

Reference:

1. NICE Clinical Guideline 153: The assessment and management of psoriasis. National Institute for Health and Care Excellence. October 2012. http://publications.nice.org.uk/psoriasis-cg153 [Accessed 17/04/13]

Supplement: Lothian Prescribing Indicators 2013/14 in general practice

Supplement: Recent SMC and Lothian Formulary Committee Recommendations

The supplements can be accessed via the LJF website www.ljf.scot.nhs.uk in 'Prescribing Bulletins'.

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