LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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In this issue …

LJF updates - anxiolytics, hypnotics, antidepressants

Sections of the Lothian Joint Formulary Chapter 4 Central Nervous System have been reviewed and updated. This article summarises the changes made to hypnotics, anxiolytics and antidepressants. Please refer to the LJF website for more information.

Acute anxiety states

The LJF no longer recommends pharmacological treatment as first choice for acute anxiety. The prescribing notes highlight that anxiety is a normal response to stress. In line with current practice, diazepam should be used with caution (rather than avoided as was previously recommended) if there is a history of drug or alcohol misuse.

First choice:	
	non-pharmacological treatment
Second choice:	
	diazepam

Anxiety disorders

First line for anxiety disorders remains no pharmacological treatment with SSRIs still second choice. Antidepressants recommended for treatment of anxiety disorders are now displayed in the form of a table to reflect the current licensed indications of the SSRIs.

Generalised anxiety disorder (GAD), panic disorder, social anxiety disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD)

First choice:	
	non-pharmacological treatment
Second choice:	
	Selective Serotonin Re-uptake Inhibitors (SSRI) refer to SSRI licensed indications and recommended doses table

Hypnotics

For insomnia, the first choice is no pharmacological treatment with zopiclone still second choice. The prescribing note now clarifies that a short course of zopiclone lasting one week is preferred as per BNF advice.

First choice:	
	non-pharmacological treatment
Second choice:	
	zopiclone

Depression

Antidepressants are not recommended for the initial treatment of mild depression because the risk benefit ratio is poor.

Drug treatment of major depression

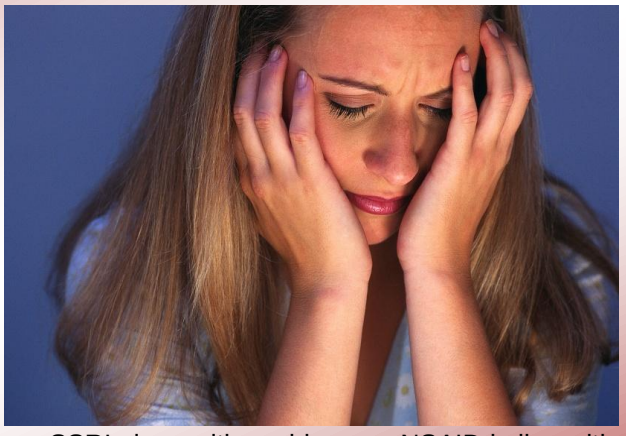
Newly diagnosed depression	
First choice:	
	fluoxetine
Second choice:	
	citalopram
Recurrence of depression	
First choice:	
	previously successful antidepressant e.g. amitriptyline

Appendix 7 section on depression in pregnancy and the puerperium is updated to reflect recent SIGN guidelines.[1] Fluoxetine has been removed as a second choice drug option because of the potential risk of congenital cardiac defects in infants exposed to fluoxetine in early pregnancy, similar to that seen with paroxetine. Sertraline remains the preferred SSRI although the comment that it appears to be safer in pregnancy compared to other SSRIs has been removed. Since implications for breastfeeding need to be considered, it is now noted that doxepin is the only antidepressant that is contraindicated in breastfeeding.

Depression in pregnancy and the puerperium

First choice:	
	non-pharmacological treatment
Second choice:	
	amitriptyline
or	**sertraline**

Key points:



- A new prescribing note has been added to state if there is a partial or lack of response to a tolerated SSRI, consideration should be given to switching to a different SSRI before trying a drug with a different mode of action.
- Appendix 4 detailing guidance for **swapping and stopping** antidepressants has been updated.
- A reminder is given that caution should be exercised with tricyclic antidepressants in patients with CHD and cardiac arrhythmias.
- Due to an increased risk of bleeding, prescribing a gastroprotective drug should be considered when giving an SSRI along with aspirin or an NSAID in line with NICE guidance[2].
- The prescribing notes have been updated to include the recommendation to consider withdrawal of treatment if the patient has been symptom-free for one year unless they have experienced two or more episodes in the past.

References:

1. Management of perinatal mood disorders. SIGN 127. Scottish Intercollegiate Guidance Network. Healthcare Improvement Scotland. March 2012. www.sign.ac.uk
2. The treatment and management of depression in adults. Clinical Guideline 90. National Institute for Health and Care Excellence. October 2009. www.nice.org.uk

Thanks to Alison Rowe, Specialist Clinical Pharmacist, Royal Edinburgh Hospital

Involving non-clinical staff in medication review in general practice

Since 2003/04 there has been a 34% increase in the number of items dispensed in Scotland. Figures for 2012/13 show 96.8 million items dispensed at a net cost of £1.12 billion.[1] Repeat prescribing accounts for approximately 75% of all prescriptions written in primary care.[2] Medicines waste is estimated to be £20 million per annum in Scotland.[3] Robust repeat prescribing procedures can minimise waste and can improve patient safety.[4]

The repeat prescribing process has been identified as a core element of the administrative staff member's role; one that requires collaboration, communication and co-ordination between clinicians and non-clinical staff. One method of improving the repeat prescribing process within GP practices is to train and resource designated non-clinical administrative practice staff to improve medicines management. The aim is to equip practice staff with the skills and confidence to undertake a technical, non-clinical check of repeat medicines and provide safe and robust systems. Under protocol, they are able to alter specific, non-clinical information on patient's medication records and highlight pertinent safety issues to clinicians.

The areas covered by Non-clinical Medication Review training are:

- Inactivation of repeat items that have not been issued for an agreed period of time
- Compliance checks of early/late ordering
- Process for uncollected prescriptions including destruction
- Recording community pharmacy urgent supplies via CP(US) forms
- Quantity re-alignment to an agreed prescribing interval, e.g. 56-day supply
- Lost/missing prescriptions.

The NHS Lothian Primary Care Pharmacy Team, in partnership with colleagues from eHealth, provides training for practices operating the InPS VISION clinical IT system. In addition, one-to-one training sessions are available on request for EMIS practices.

Once training is completed, all reviews are undertaken in line with practice-specific protocols as agreed by the clinicians. Currently, 157 members of staff from 84 practices across NHS Lothian have completed the training for either VISION or EMIS.

There have been a number of additional benefits arising from both the training sessions themselves and process implementation within the practices:

- Improved networking and peer support between practices
- Sharing of best practice
- Improved communication with local community pharmacies
- Improved use of the practice clinical system
- Improved job satisfaction for staff involved
- Supports the safety climate survey aspect of QOF in 2013/14.[5]

References:

1. Prescribing & Medicines: Prescription Cost Analysis. 2012-13. Information Services Division. NHS National Services Scotland. 25 June 2013. https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-06-25/2013-06-25-Prescribing-PrescriptionCostAnalysis-Report.pdf?54179018736 [Accessed 21/02/14]
2. Saving time helping patients. A good practice guide to quality repeat prescribing. National Prescribing Centre. NHS. January 2004. www.npc.nhs.uk/repeat_medication/repeat_prescribing/resources/library_good_practice_guide_repeatprescribingguide_2004.pdf [Accessed 21/02/14]
3. Prescribing in general practice in Scotland. Audit Scotland. January 2013. www.audit-scotland.gov.uk/media/article.php?id=226 [Accessed 21/02/14]
4. Swinglehurst D *et al.* BMJ 2011:*343*:d6788. www.bmj.com/content/343/bmj.d6788 [Accessed 21/02/14]
5. Scottish Quality and Outcomes Framework 2013/2014. Guidance for NHS Boards and GP practices. May 2013. BMA. The Scottish Government. www.sehd.scot.nhs.uk/pca/PCA2013(M)02guide.pdf [Accessed 21/02/14]

LJF update – clopidogrel for acute coronary syndrome

There has been a change to LJF guidance for clopidogrel in acute coronary syndrome (ACS). Dual antiplatelet therapy with aspirin 75mg once daily and clopidogrel 75mg once daily is now recommended for all ACS regardless of ST elevation and/or stenting. The clopidogrel should be stopped after 12 months, continuing on aspirin alone. Further information, including information on antiplatelet therapy for elective stent insertion can be found at www.ljf.scot.nhs.uk.

For urine formation
Three principles of UTI management

Management of urinary tract infections (UTIs) is an almost daily occurrence for most GPs. Many will have developed an individual clinical approach based on experience, patient preference and historic evidence. Lothian recommendations are available on the LJF website, see Adult Chapter 5, Infections. SIGN 88[1] provides a review of current evidence and suggests treatment principles:

1: Asymptomatic bacteriuria (bacteria in urine not due to contamination) **in women is not a disease:**

- Increasingly common in women > 65 years and often represents normal body flora
- All catheterised patients have bacteriuria
- Only treat in pregnancy
- Treatment of asymptomatic bacteriuria may predispose to recurrent cystitis[2]

2: Diagnosis of UTI based on signs and symptoms:

(dysuria; polyuria; haematuria; urgency; frequency; suprapubic tenderness; NO vaginal discharge)

- For non-pregnant women (18-65 years) with non-recurrent ≥ 3 signs or symptoms of UTI consider empirical antibiotics and no urinalysis or mid-stream sample of urine (MSSU)
- For non-pregnant women (18-65 years) with non-recurrent ≤ 2 signs or symptoms of UTI then check urinalysis. If nitrites present then consider empirical antibiotics without MSSU

3: UTI requiring MSSU – i.e. 'everyone else':

- These patients (not covered by 1 and 2, above) need an MSSU
- Start immediate antibiotics for: upper UTI; children; men and pregnant women
- Watch and wait for result if mild symptoms and patient is well

References:

1. Management of suspected bacterial urinary tract infection in adults. SIGN 88. Scottish Intercollegiate Guidelines Network. Healthcare Improvement Scotland. July 2012. www.sign.ac.uk
2. Gupta K. BMJ 2013;346:f3140. www.bmj.com/content/346/bmj.f3140 [Accessed 21 February 2014]

Prescribe nitrofurantoin capsules

Due to manufacturing issues, nitrofurantoin tablets are currently only available at a premium cost. As a result prescribers are recommended to use nitrofurantoin capsules until further notice. Vision eLJF-FMY and eLJF-CLINICAL files will reflect this advice from April 2014, when the next update is due.

Supplement: Lothian Prescribing Indicators 2014/15 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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