LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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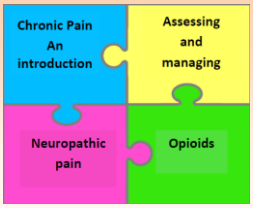
In this issue …

Chronic pain – we need to look beyond drug treatment…



The first of a series of articles on chronic pain.

Chronic pain is continuous long-term pain of more than 12 weeks, or beyond the time when an acute injury would be expected to have healed.[1] Management strategies differ from acute pain.

SIGN guideline 136, Management of Chronic Pain[2] is aimed at primary care clinicians and other non-pain specialists who encounter chronic pain on a regular basis. The SIGN website includes links to three concise electronic pathways which guide assessment, early management and care planning, management of neuropathic pain and strong opioids.

The SIGN guideline triggered a review of the LJF analgesics section. Almost all of the LJF first or second choice drug recommendations have remained the same. However, the emphasis of the section has changed significantly with more extensive prescribing notes, particularly in relation to non-pharmacological options and detailed advice on the use of strong opioids. Advice is now included for dose reduction of paracetamol in patients who are malnourished or who have significant weight loss, as they may be more susceptible to paracetamol-induced liver damage even at appropriate doses due to glutathione depletion. Patients who weigh <50kg should be prescribed 500mg every 4 to 6 hours.

Implications for clinical practice

Our experience of acute pain has the useful function of deterring us from incurring additional tissue damage following an injury. Chronic non-cancer pain in contrast does not serve any useful biological function and should be differentiated, and treated very differently, from both acute pain and pain in palliative care.

Management of chronic pain, and the problems that can arise from continued use of ineffective and potentially harmful drugs, consumes a large amount of resource. Time invested at an early stage to educate patients and avoid ineffective treatments can both improve patient care and make better use of that limited resource.

Once other causes have been reasonably excluded many patients are relieved to be given a diagnosis of 'chronic pain' and to be told that no further investigations are required. It is important to be realistic and advise that complete pain control is rare without unacceptable side-effects.

Key messages

- **Always offer non-pharmacological therapy in addition to (or in place of) drug treatments; non-pharmacological therapies include: referral for exercise therapy, self management strategies, referral to the pain management programme, and many others.**
- **Refer all patients to the chronicpainscotland.org website where other educational and support resources can be accessed; the britishpainsociety.org also produces information for patients.**
- **There is no single analgesic that will work well for every patient, therefore it is often necessary to trial a number of drugs (even within the same class) before finding one that is effective.**
- **Most drug treatments tend to produce EITHER a significant improvement (around 50% reduction in pain score) OR very little change (with not much in between) therefore newly prescribed drugs should be reviewed after two to four weeks at an appropriate dose and stopped if not working well.**
- **Patients using analgesics to manage chronic pain should be reviewed at least once a year, and more frequently if medicines are changed, pain not controlled or if co-morbitities.[2]**

References

1. Management of chronic pain in adults. National Health Service Quality Improvement Scotland. February 2006.
2. Management of chronic pain. Clinical Guideline 136. Scottish Intercollegiate Guidelines Network. December 2013. www.sign.ac.uk

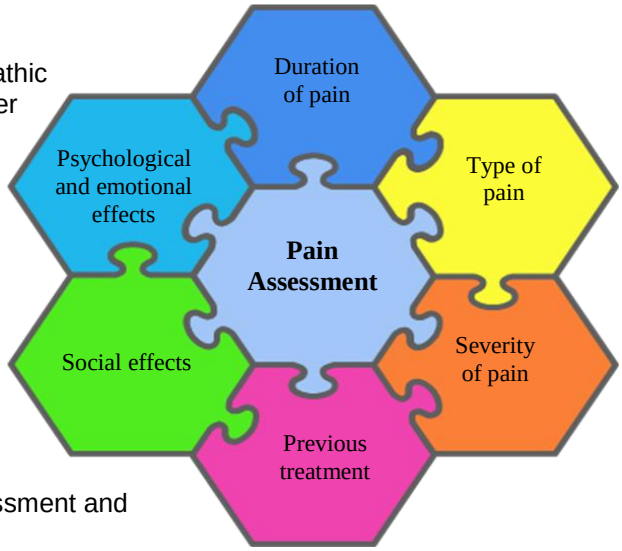
Thanks to Dr John Hardman, RCGP Scotland representative on clinical guideline development group for SIGN 136: Management of Chronic Pain, and GP, Dalhousie Medical Practice, Bonnyrigg.

Assessing and managing chronic pain

The SIGN 136 pathway for chronic pain assessment, early management and care planning advises that assessment for complex patients can be divided over multiple consultations using a patient centred approach.

Pain type can usually be determined by focused history taking.

- It is most useful to identify the presence or absence of neuropathic pain as the treatment options are very different from most other chronic pain.
- It is also useful to identify visceral pain, fibromyalgia and somatoform (functional or medically unexplained) pain as opioids should generally be avoided for these types of pain.



Any 'red flags' should be identified and the duration of pain established. The diagnosis of chronic pain should be recorded and coded electronically in the patient record.

Patients with significant psychological and social factors related to chronic pain, major co-morbidities and other 'yellow flags' (defined in the SIGN guideline) are at increased risk of poor outcomes and should be targeted for more comprehensive biopsychosocial assessment and earlier referral.

Early intervention includes listening, educating and reassuring patients, acknowledging that the pain may never entirely resolve. A self management approach is to be encouraged and patients supported to stay active and remain at work. The underlying cause of the pain should be treated where possible. Identification and treatment of co-existent depression both improves mood and reduces pain.

Scottish Palliative Care Guidelines launched

The Scottish Palliative Care Guidelines were published online in November 2014. These revised guidelines are designed for use by healthcare professionals working in any care setting in all Health Boards. They replace the previous 3rd edition of the NHS Lothian Palliative Care Guidelines, except for the sections on patient information leaflets, anticipatory care planning and non-cancer palliative care.

The guidelines include a few medicines and preparations that are only recommended for use on specialist advice, and some that are not approved in all Health Boards including NHS Lothian. A couple of examples are shown below.

Examples of differences in recommendations	
Scottish Palliative Care Guidelines	**NHS Lothian**
oxycodone injection 50mg/mL	oxycodone injection 10mg/mL
fentanyl tablets (Effentora®)	fentanyl tablets (Abstral®)

Regional cancer guidelines should be used for patients receiving oncology treatment. You can seek advice from your pharmacist, a palliative care specialist or local oncology services.

Information about palliative care guideline resources and advice in NHS Lothian can be accessed via these links:
NHS Lothian Internet Home > Services > Health Services A-Z > Palliative Care > Palliative Care Guidelines
NHS Lothian Intranet NHSLothian > Healthcare > A-Z > Palliative Care > Palliative care guidelines

Paper copies of previous versions of the guidelines should be destroyed.

An App for the guidelines and an A5 printed booklet of selected guidelines is also due for release in 2015.

Thanks to Dorothy McArthur, Principal Pharmacist, Palliative Care, St Columba's Hospice and Marie Curie Hospice.

LJF updates

Nasal allergy – LJF section 12.2.1

Significant cost savings could be made by prescribing the formulary 2nd choice of fluticasone furoate (Avamys®) rather than the non-formulary fluticasone propionate (Flixonase®). Non-formulary prescribing accounts for 60% of all the expenditure on nasal steroids. If the formulary 2nd choice was prescribed instead of fluticasone propionate, there would be a cost saving of approximately £115k per year. The patient would still be getting fluticasone as the steroid of choice, but would be receiving a more cost-effective option.

Beclometasone nasal spray, the LJF first choice, is also included in the LJF Minor Ailments Formulary for allergic rhinitis in adults.

Nasal steroid	Expenditure (primary care) (Dec 2013 to Nov 2014)	% of total nasal steroid spend	Unit cost
beclometasone (LJF first choice)	£153,000	18% (but 44% of items)	£2.12
fluticasone furoate (Avamys®) (LJF second choice)	£188,000	22% (but 19% of items)	£6.44
fluticasone propionate (Flixonase®) (non-formulary)	£218,000	25% (but 10% of items)	£11.01
all other non-formulary nasal steroid sprays	£301,000	35% (but 27% of items)	n/a

Oral anticoagulants and management of atrial fibrillation – LJF section 2.8.2

Warfarin remains the first choice anticoagulant for prophylaxis of stroke and prevention of systemic embolism in non-valvular atrial fibrillation in those patients with a moderate and high risk (age >65 years or <65 years with additional stroke risk factors). Apixaban is second choice where there is poor INR control on warfarin or allergy to/intolerable side-effects from warfarin.

A new prescribing note has been added to this section, providing information on apixaban for use in patients undergoing cardioversion for atrial fibrillation. The criteria for use are slightly different than those for the use of apixaban in stroke prevention in patients with atrial fibrillation. If the cardioversion is successful then the use of apixaban is short term only.

Useful resources for healthcare professionals

Medicines Compliance Aid Database

UK Medicines Information (UKMi www.ukmi.nhs.uk) has launched a Medicines Compliance Aid database, which makes recommendations on the suitability of transferring solid dose medicines from the manufacturers' original packaging into multi-compartment compliance aids (MCAs). This is based on factors including physico-chemical stability and characteristics of the medicine. The database can be searched by the brand or generic name of the medicine. The medicine is given a traffic light colour-coded UKMi recommendation as to whether it is suitable or not to be placed in a MCA.

UKMi recommend using the database alongside the Royal Pharmaceutical Society's Guidance Improving patient outcomes through the better use of multi-compartment compliance aids.

Drugs in Lactation

The UK Drugs in Lactation Advisory Service has compiled a database of information on common drugs used during breastfeeding. Drugs are assigned a risk category ('No', 'Caution' or 'Yes') on the basis of risk to the breastfed infant, and the quality/volume of evidence available. The information is summarised and includes any suitable alternatives and links to further information.

‘Specials’ and ‘Pay & Report’ - unlicensed

Two new sections of the Scottish Drugs Tariff[1], Part 7S for unlicensed ‘specials’[2] and Part 7U for unlicensed ‘Pay & Report’ products[3] were introduced in 2013 with the purpose of standardising prices. Creating a tariff price for a specific product also aims to generate competition between manufacturers. The inherent risk of this approach is that it may be incorrectly seen as an endorsement of prescribing these products on the NHS. Unlicensed medicines should only be used where their use is clearly justified and their clinical and pharmaceutical benefits are considered to outweigh the risks involved.[4] Best prescribing practice should include a review of whether the medicine is essential[5] and if a UK licensed product can meet the clinical need, even off-label, it should be used instead of an unlicensed product.[4]

‘Specials’

These are unlicensed medicinal products for human use which have been specially manufactured or imported to the order of a doctor, dentist, nurse independent prescriber, pharmacist independent prescriber or supplementary prescriber for the treatment of individual patients.[4] Examples of ‘special needs’ include an intolerance or allergy to a particular ingredient, or an inability to ingest solid oral dosage forms.

There are currently around 70 ‘special’ medicines listed in Part 7S, the majority of these being suspensions or solutions. Only a few of these are included in the BNF; these are chloral hydrate 500mg/5mL mixture and spironolactone 25mg/5mL and 50mg/5mL oral solutions. Adults with swallowing difficulties are often changed onto suspensions or solutions which are unlicensed ‘specials’.

Pay & Report

These are marketed products without formal marketing authorisation that are not included in the Advisory Committee on Borderline Substances (ACBS) list.[3] NHS Lothian has the authority to challenge prescribers of these products and to invoice them if individual clinical need cannot be demonstrated.

Some ‘Pay & Report’ products share the same brand name as licensed medicines. For example Oilatum® Cream is classed as a medicine, whereas Oilatum® Bath Formula is not.

There are currently around 50 ‘Pay & Report’ products listed in part 7U. The list does not include all products that may be subject to ‘Pay & Report’, and inclusion of particular products on the list does not represent an endorsement by NHS Scotland that these products should be prescribed.

Did you know?

Omeprazole suspension is classified as **black** (not recommended) under NHS Lothian ADTC policy for unlicensed medicines, as prescribers should not be using an unlicensed preparation when a licensed alternative is available. Licensed alternatives would be other formulations of proton pump inhibitors.

References:

1. The Scottish Drug Tariff. Primary and Community Care Directorate, Scottish Government. www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/ [Accessed 20.02.15]
2. Pharmaceutical Services: Reimbursement of Special Preparations and Imported Unlicensed Medicines. NHS Circular: PCA(P)(2013) 4. The Scottish Government. 31 January 2013. www.sehd.scot.nhs.uk/pca/PCA2013(P)04.pdf [Accessed 20.02.15]
3. Pharmaceutical Services: Amendment to Drug Tariff: Introduction of new Pt 7U. NHS PCA(P)(2013) 32. The Scottish Government. 29 November 2013. www.sehd.scot.nhs.uk/pca/PCA2013(P)32.pdf [Accessed 20.02.15]
4. Policy and procedures for the use of unlicensed medicines. NHS Lothian. June 2014. www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/Committees/ADTC/MedicinesGovernancePoliciesADTCPolicyStatements/Pages/default.aspx [Accessed 20.02.15]
5. Appropriate prescribing for patients and polypharmacy guidance for review of quality, safe and effective use of long term medication. CEL 36 (2012). The Scottish Government. 1 November 2012. www.sehd.scot.nhs.uk/mels/CEL2012_36.pdf [Accessed 20.02.15]

Supplement: Prescribing Indicators for primary care 2015-16

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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