LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

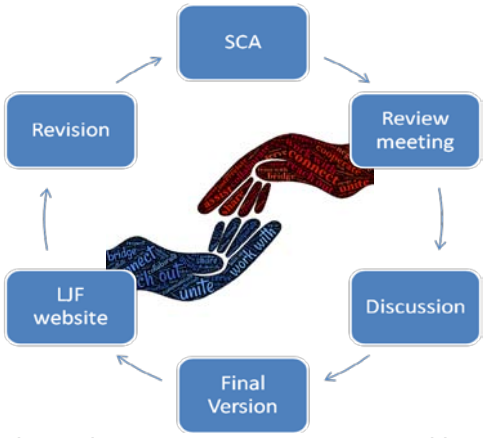
NHS Lothian

In this issue …

Issue No. 89 **January 2018**

Shared Care Agreement update

Shared Care Agreements (SCAs) aim to facilitate the seamless transfer of individual patient care between secondary care and general practice. They provide the specialist prescriber and GP with the required information to ensure the medicine is started and continued safely.



The review process was restructured last year, with an aim of improving effectiveness and efficiency.

The review of SCAs is undertaken by a review group with representatives from primary and secondary care. Meetings are every six months on a rolling programme with each SCA reviewed every two years. The SCAs are categorised into four groups

1. **Rheumatology and gastro-intestinal**
2. **Dermatology, transplant, renal and neurology**
3. **Mental health**
4. **Paediatrics, respiratory (Cystic Fibrosis) and cancer**

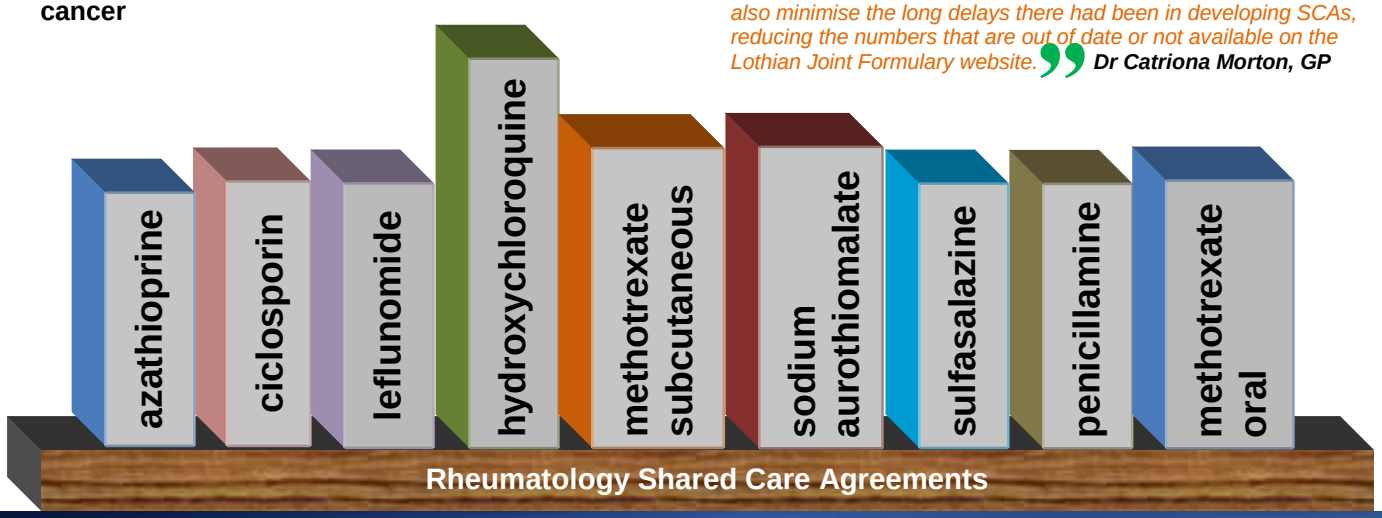
Minor amendments can be made to SCA documents as required after reaching consensus between review group members.

Rheumatology

Recent work with Rheumatology specialists involved the review and approval of nine SCAs for DMARDs - used for the treatment of inflammatory rheumatic diseases. These incorporate changes in the monitoring requirements in line with British Society for Rheumatology's updated guidance on the prescription and monitoring of DMARDs.

The process for initiating patients on these medicines was defined. The specialist service will do the baseline investigations, counsel patients and provide supply of treatment for the first 8 weeks. During this time they will provide comprehensive patient support, address any treatment-related issues and respond to patient queries via a patient helpline. On initiation of treatment, patients will be provided with pre-labelled forms for blood tests. Bloods will be taken in primary care and reported to rheumatology during the first 6 weeks of treatment. Thereafter the supply and monitoring will be undertaken in general practice.

> *"The establishment of the new SCA Group is very welcome. It means that GPs and Primary Care pharmacists can meet directly with specialist colleagues, with themed meetings. We have more time for discussion and can iron out misconceptions, both primary and secondary care becoming more aware of each other's pressures and difficulties. This should lead to improved SCAs, and a better understanding of how GPs work and what should be expected of us: there is strong GP representation on the group and a new link to the GP Sub-Committee. The new process should also minimise the long delays there had been in developing SCAs, reducing the numbers that are out of date or not available on the Lothian Joint Formulary website."* ***Dr Catriona Morton, GP***



Safety snippets

Warfarin warning: miconazole

The MHRA has published a drug safety update reminder for patients taking warfarin to avoid using over the counter miconazole oral gel.

Bleeding events, some with fatal outcome, have been reported with use of miconazole oral gel by patients on warfarin. If concomitant use is planned, exercise caution and ensure the anticoagulant effect is monitored carefully. Patients prescribed miconazole oral gel who also take warfarin should be advised that if they experience any signs of over-anticoagulation (for example sudden unexplained bruising, nosebleeds or blood in urine) to stop using miconazole and seek medical attention immediately.

This warning does not apply to other topical formulations of miconazole although caution is required.

Clozapine: constipates

Clozapine is the antipsychotic drug of choice in the LJF for treatment resistant psychosis. Link to Clozapine Handbook (available via the intranet only). Constipation associated with clozapine therapy is very common; this is thought to be due to the anticholinergic properties of clozapine. Possible complications include intestinal obstruction, faecal impaction and paralytic ileus which may be fatal.

The MHRA has recently issued a reminder of the importance of recognising early and actively treating clozapine induced constipation. As patients may not complain about constipation, they should be asked regularly about bowel habit. Healthcare professionals are reminded to advise patients to report constipation immediately and actively treat any constipation that occurs.

Remember**:** clozapine is prescribed and dispensed in secondary care and may not appear on the primary care record or emergency care summary (ECS).

Advice on use of topical antiseptics for eczema

The SIGN guideline (2011) on the management of atopic eczema in primary care states: "*A Cochrane review identified a small number of diverse studies and found no benefit for antibacterial soaps, bath additives or topical antibiotics/antiseptics in the treatment of atopic eczema*."

However, in current practice, short term use is accepted for infected exacerbations of eczema. These formulations when indicated should only be used on a short term basis due to the risk that long term use may result in sensitisation of the skin. Therefore any emollient bath and shower products which contain antibacterials/antiseptics should not be provided on repeat prescriptions.

A practice audit idea is to review all repeat prescriptions for such products and substitute them for products without antibacterials. One practice in Lothian (approximately 3,500 patients) had 41 patients on repeats for these products.

Consider switching patients from

Oilatum Plus Bath Additive (contains antiseptic)

T O

Oilatum Emollient Bath Additive or Oilatum Shower Gel

Dermol 500

T O

ZeroAQS cream

Interaction between antiretroviral therapy (ARVs) and corticosteroids

There have now been multiple reports of HIV patients on ARVs receiving corticosteroids via oral, intra-articular or inhaled routes, who have then presented with iatrogenic diseases such as Cushing's Syndrome.

HIV antiretroviral regimens that include protease inhibitors often contain 'booster drugs' which act to inhibit liver enzymes. These booster drugs can affect many other medications, in addition to the HIV protease inhibitors. One such group of other drugs affected are corticosteroids.

Boosters, ritonavir and cobicistat, work by inhibiting CYP3A4 enzymes, blocking the metabolism of protease inhibitors and increasing the levels of them in the system. The inhibition of these enzymes block the metabolism of **some** corticosteroids in a similar way, and likewise increase the amount of steroid in the body

Prescribing these booster-containing ARVs and steroids in combination has led to patients developing cushingoid symptoms (e.g. weight gain, central obesity, 'moon' face, buffalo humps, high blood pressure, high blood glucose levels, easy bruising, skin straie and thinned skin).

Prior to prescribing any form (i.e. oral, inhaled or intra-articular) of steroids for a patient on ARVs, drug interactions should be checked.

Resources which can be used to check these interactions

- Liverpool HIV Drug interaction checker
- Stockley's Drug interaction checker
- The BNF

Contraindicated treatments should never be co-prescribed and an alternative should be sought. When combinations that are labelled 'caution' are prescribed, the patients should be monitored closely for any elevation in cortisol levels.

These combinations should be considered with caution and monitored carefully

- intra-articular/intra-muscular injection
- inhaled corticosteroids
- oral/topical/eye drops

Medicines for the doctor's bag

Guidance for the use of medicines during normal working hours

Previous guidance was provided in 2006 to General Practitioners regarding medicines to carry for immediate patient use during working hours. It was identified that the list required to be reviewed and updated to ensure that it was still fit for purpose. These updated recommendations reflect current evidence and practice, and are in line with the Lothian Joint Formulary[1], the Lothian Unscheduled Care Service stock list, and key references[2,3].

These medicines are intended for immediate use at times when community pharmacies are also open. The medicines should be ordered using a stock order form (GP10A).

Good practice systems to ensure that medicines are in date should be in place. It is suggested that a named person in the practice has responsibility for co-ordinating and monitoring this. It is hoped that this will enable sessional GPs to have access to a standardised stock of drugs, whichever practice they are in, and that this will reduce clinical risk. **See the enclosed insert for full details.**

References

1. Lothian Joint Formulary www.ljf.scot.nhs.uk
2. Drugs for the doctor's bag: 1 - Adults. Drug & Therapeutics Bulletin. 2015;*53*:56-60. http://dtb.bmj.com/content/53/5/56.abstract
3. Drugs for the doctor's bag: 2 - Children. Drug & Therapeutics Bulletin. 2015;*53*:69-72. http://dtb.bmj.com/content/53/6/69.abstract

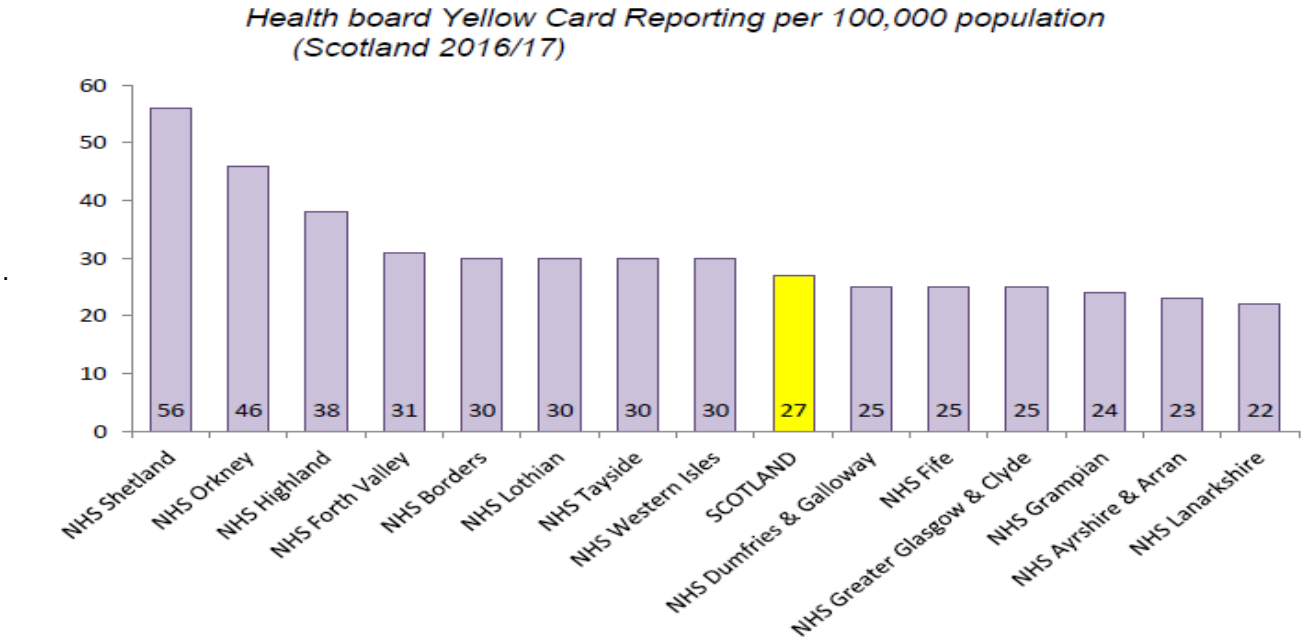
Yellow Card Scotland annual report

The Yellow Card reporting data for Scotland for the Year 2016-17 are now available in the Yellow Card Centre (YCC) Scotland Annual Report.

There were 1,463 Yellow Card Reports in Scotland and 256 of these came from Lothian. That's a 1% increase on 2015-16 for Scotland and a 4% increase for Lothian.
Overall patient group reporting increased by 7% in Scotland and made up 30% of all the reports in Lothian.
Locally, patient groups remain the highest reporting group, followed by hospital pharmacists (20%) and hospital doctors (18%).
Of the reports submitted by healthcare professionals, 65% were made from within hospitals in Lothian.

Consistently with the rest of Scotland, GP reporting has continued to decline in Lothian over the last four years; there was a further 8% decrease in Scotland since 2015/16. Nurse reporting has also declined by 22%. There have been increases in GP reporting throughout the rest of the UK where electronic YC reporting is embedded within clinical systems (such as SystmOne and Vision). We recognise this issue in YCC Scotland but do encourage you to report online, via the App, or on paper until embedded reporting is available in Scotland.

NHS Lothian was above the national average (27/100,000) for Yellow Card reporting with 30 reports per 100,000 population.



Reporting is everyone's responsibility. Please stay up to date on key medicines safety issues by subscribing to the MHRA Drug Safety Updates via http://www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/index.htm

The Yellow Card App will soon be getting a revamp to make it much more user friendly.

Thank you to everyone who submitted a Yellow Card report. This is the most important way to identify safety concerns, especially those which were previously not recognised for both old and new medicines. Awareness of any new risks is vital to protect our patients from preventable harm.

Supplements:

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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