LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

NHS Lothian

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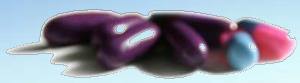

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Probiotics on the NHS

Bacteria or yeast ingested orally are generally termed probiotics. They may be administered as a single type of organism or a defined mixture, aiming to beneficially alter the microbial ecology of the gut.[1]

The Advisory Committee on Borderline Substances (ACBS) advises on the circumstances in which these products may be regarded as drugs. There are two products: Vivomixx and VSL#3® listed in the borderline substances. They may be prescribed on the NHS specifically for the *'maintenance of remission of ileoanal pouchitis only in adults as induced by antibiotics'.*[2] Only the VSL#3® product is approved for use on the Lothian Formulary.[3]

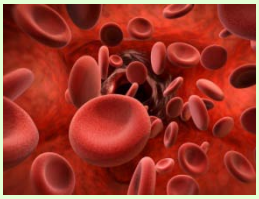
A lack of evidence for using probiotics in Inflammatory Bowel Disease is highlighted by Cochrane reviews, which means only the ACBS approved indication is supported. Patients not meeting the ACBS criteria can be informed that VSL#3® or other probiotics are available in pharmacies and health food shops. Patients should be counselled on the lack of evidence for benefit in any indication other than the ACBS approved one.

Recommendations:[4]

- Review all patients on probiotics and check indication, is in line with the ACBS approved indication i.e. for use under the supervision of a physician, for the maintenance of remission of ileoanal pouchitis induced by antibacterials in adults.[2]
- Advise any patients that probiotics are available over-the-counter, if they wish to try them. However, ensure patients understand there is a lack of evidence supporting a benefit of probiotics in any indication other than that approved for use by ACBS.
- Regularly review effectiveness of VSL#3® in those patients who meet the ACBS criteria. Consider stopping therapy where there is insufficient clinical benefit.

1. Mowat C *et al.* Gut 2011 May; 60(5):571-607 doi:10.1136/gut.2010.224154
2. www.drugtariff.nhsbsa.nhs.uk/#/00548381-DA/DA00548270#d2e4598/V accessed 11 October 2018
3. www.ljf.scot.nhs.uk/LothianJointFormularies/Adult/1.0/1.5/Pages/default.aspx
4. www.prescqipp.info/component/jdownloads/send/122-probiotics/1460-bulletin-82-probiotics

DOACs and antidepressants - risk of interactions



UKMi publish medicines Q&As for NHS healthcare professionals to answer common or unusual enquiries made to Medicines Information services.

A recent review was published on the interactions between DOACs and antidepressants that are known inhibitors/inducers of CYP3A4 or P-glycoprotein (P-gp) and also those that affect haemostasis.

Serotonin is released from platelets in response to vascular injury and promotes vasoconstriction and changes in platelets that lead to aggregation. Thus, SSRIs and SNRIs might deplete platelet serotonin, leading to a reduced ability to form clots and a subsequent increase in the risk of bleeding.

Whilst DOACs appear to have fewer drug interactions than warfarin, use with strong inhibitors or inducers of CYP3A4 or P-gp can result in clinically significant interactions. Combining with lack of familiarity with these drugs, it may result in potential drug interactions being overlooked, leading to patient harm, mainly because patients taking DOACs do not require regular blood monitoring. Ensure patients are aware of increased bleeding risk and when to seek medical advice.

Supporting medicines safety for all

Help improve the safety of medicines taken during pregnancy

The Medicines & Healthcare Products Regulatory Authority (MHRA) recently sent out a reminder regarding the importance of reporting any suspected adverse reaction to medicines taken during pregnancy.[1] These can be adverse effects experienced by the mother, the baby (or child.) Reporting is vital for improving understanding of the safety of medicines for women and children, and to ensure that healthcare professionals are aware of the risks when prescribing.

Under-reporting in this important area may lead to missing drug safety signals, including miscarriage, congenital anomalies, or developmental disorders which may not be noticeable until later in the child's life.

Obstetricians and midwives have a key role in providing information on pregnancy outcomes. Any patient, carer or healthcare professional can report a Yellow Card when they suspect a medication used during pregnancy has caused an adverse reaction or abnormal pregnancy outcome. Reports should also be made when an adverse effect is suspected in a pregnancy that was not carried to term.

UK Teratology Information Service (UKTIS)

Patient information leaflets are available via BUMPS (provided by the UKTIS) at [www.medicinesinpregnancy.org/](www.medicinesinpregnancy.org/*)*

*You can also report **any** exposure during pregnancy to the UKTIS, regardless of whether any adverse reaction has occurred.*

*This should not replace the advice of a healthcare professional.

Yellow Card Centre Scotland

Yellow Card reporting

- **via Vision:** many GP practices across Scotland are now able to submit Yellow Cards directly via Vision. This feature enables Yellow Card reports to be created directly from the current ***"Add Drug Allergy and Intolerance"*** screen, when recording a new adverse effect or inactivating a repeat prescription due to an adverse effect, making reporting quick and easy! When a Yellow Card report is created, it is automatically populated with relevant patient and practice information. When completed it is saved in the patient record, and a report is sent directly to the MHRA.
- **via the website:** https://yellowcard.mhra.gov.uk/
- **via the free Yellow Card app**: download now from the Apple App Store or Google Play Store
- **via phone**: 0800 731 6789 (10am to 2pm Monday-Friday)
- **via paper forms**: they can be downloaded from the website and are available in the BNF and MIMS.
- **For further information on the Yellow Card Scheme refer to the website http://www.yccscotland.scot.nhs.uk**

Anticipatory medicines: assessing diversion risk

The Controlled Drug Governance team have been made aware of two occasions where anticipatory medicines have gone missing from patients' homes many months after being prescribed.

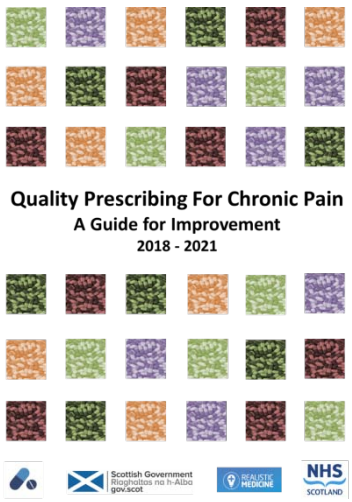
On both occasions the medicines had been prescribed for the patient who had subsequently improved and so didn't have an immediate need for the medicines. As such no nurse was visiting and routinely counting the stock.

When the nurses next had reason to visit they identified a shortage. It is therefore suggested that if this situation presents, a risk assessment, based on the individual patient's circumstances, is undertaken and consideration given to whether removing the anticipatory medicines might be appropriate.

Routine practice would be for patients or carers to return medicines to a community pharmacy. Nurses, doctors or pharmacists can remove medicines, when acting as the patient's representative, where there is a risk of diversion or misuse from the medicine remaining in the home.

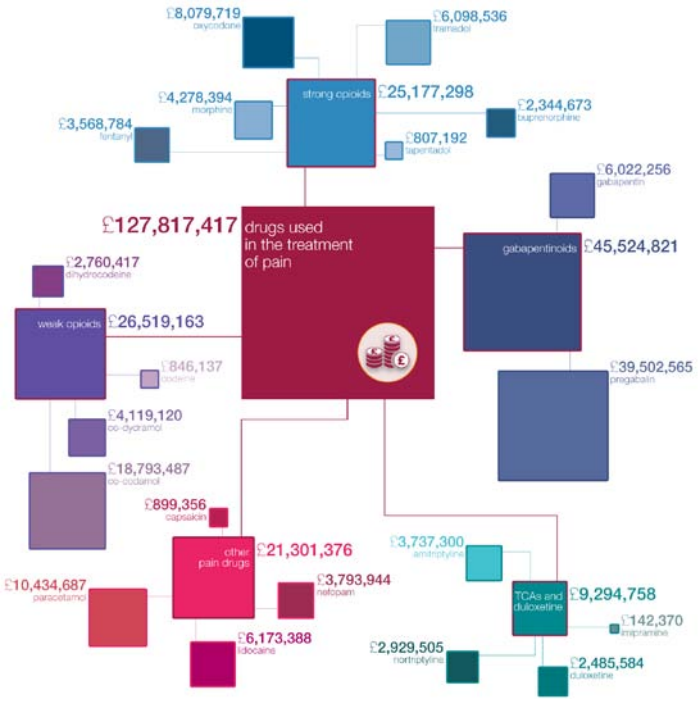
Pain management - review, review, review

The third national prescribing strategy, *Quality Prescribing for Chronic Pain 2018 - 2021*, aims to fulfil an unmet need in providing a strategic approach to prescribing for chronic non-cancer pain. This condition affects 18% of the population and presents a major clinical challenge.[1] Most patients are managed in primary care and there is evidence of wide variation in clinical practice and resource provision. Best practice would include supported self-management; psychological based interventions; physical therapies and pharmacological management.



Chronic non-cancer pain is more commonly part of multi-morbidity, rather than a single disease entity and should be considered in the broader context of polypharmacy management. *Polypharmacy Guidance 2018* remains the core strategic approach with focus on systematic holistic patient review and an emphasis on *what matters to me*[2], which supports shared decision-making regarding realistic treatment goals.

The challenges of managing chronic pain are reflected in patients' experiences of the condition.[3] Common themes include: a struggle to maintain a sense of worth, while feeling misunderstood and not believed; a diagnosis is highly valued; negotiation of the healthcare system is complex. The recommendation is to recognise that the patient with chronic non-cancer pain is someone whose life has changed.



A key concept with the pharmacological management of chronic non-cancer pain is to recognise that individual response to analgesia is bimodal, so pain relief is either good (above 50% improvement) or poor (below 15% improvement).[1] Responders should achieve good pain relief and improvements in fatigue, depression and sleep interference without side effects. Non-responders (below 15%) will be apparent after two to four weeks, and treatment should be stopped. It is for this reason that the ideal pharmacological management of patients with chronic non-cancer pain requires regular review until agreed realistic treatment goals are achieved.

First-line pharmacological management is with paracetamol and/or non-steroidal anti-inflammatory drugs, but published data shows a continual increase in the volume of prescribed opioids, gabapentinoids, lidocaine and nefopam to manage moderate to severe, chronic non-cancer pain.[4]

References

1. Management of chronic pain. SIGN 136. www.sign.ac.uk/sign-136-management-of-chronic-pain.html
2. Healthcare Improvement Scotland www.whatmatterstoyou.scot
3. Toye F *et al.* Br J Gen Pract 2013;63(617):e829-e841. https://doi.org/10.3399/bjgp13X675412
4. Freynhagen R *et al*. BMJ 2013;346:f2937. https://doi.org/10.1136/bmj.f2937
5. Moore A *et al.* BMJ 2013;346:f2690. https://doi.org/10.1136/bmj.f2690

Key messages for use of analgesics in NHS Lothian:

- Gabapentinoids use is below the Scottish average, but is increasing
- Morphine use is only 40% of total strong opioids despite being first line on the LJF
- The number of patients on long term strong opioids is the lowest in Scotland
- Lidocaine patch use is the fourth highest in Scotland and increasing

‘Brown Bag’ domiciliary medication prescribing review project

GPs at an Edinburgh practice carried out holistic reviews of 57 housebound patients in their own homes. Patients were selected by individual GPs who identified those patients considered most likely to benefit from review. Payment was available to the practice to allow backfill for the time required to undertake the reviews.

GPs had the benefit of being able to spend 45-60 minutes with a patient, compared with 10 minutes for a routine appointment. There was a focus on thorough medication review and any medicines that were no longer required were discontinued in line with Realistic Medicine. The number of changes made to patients’ medicines’ varied from no changes to five changes. The quality of prescribing and rationalisation of medication was a key aim.

GPs used this opportunity to address the safety of medicines use, with medicines that had been discontinued and out of date medicines being removed from the patient’s home. On some occasions medicines lying around the house out of packaging were removed*, including a large biscuit tin full of assorted loose tablets (see photo).*

Savings made on medicines stopped was on average £317.32 per patient. During the visits, stockpiled medicines were removed at a value of £2,177.

GPs also reviewed other aspects of patient care including monitoring of blood tests, updating the Key Information Summary (KIS) and addressing issues relating to safety of the home environment.

Informal feedback indicates a high level of satisfaction, with patients appreciating the time spent with the GP and the chance to discuss the medication regimen and reasons for rationalisation. The project was deemed a success and has been taken up by a number of Edinburgh practices this year.

Pharmaceutical waste disposal

Pharmaceutical waste from GP practices should be disposed of in the correct manner in order to support appropriate waste management. This includes the disposal of unused, expired and recalled doctors’ bag and emergency drugs, and denatured controlled drugs. The ‘blue top’ or ‘yellow top’ pharmaceutical waste bins are the approved route for safe disposal.

Best practice includes leaving drugs in original packaging to allow identification. However don’t include empty boxes or the package insert. All sharps and used ampoules, used vials and used syringes should be disposed in a ‘red top’ sharps bin.

Controlled drugs should be denatured before disposal. Unused, expired and recalled immunisations should be returned to the supplier where this is possible.

Pharmaceutical waste bins can be ordered by each practice as below. Once a bin is ready for collection, i.e. ¾ full it can be collected by the regular NHS Lothian van, which attends each practice.

Pharmaceutical Waste Bins,
Waste Management Section,
St John’s Hospital, Livingston.
Tel No: 01506 523620 (available after 1 pm)

Correspondence:
Medicines Management Team (MMT)

0131 537 8461

prescribing@nhslothian.scot.nhs.uk