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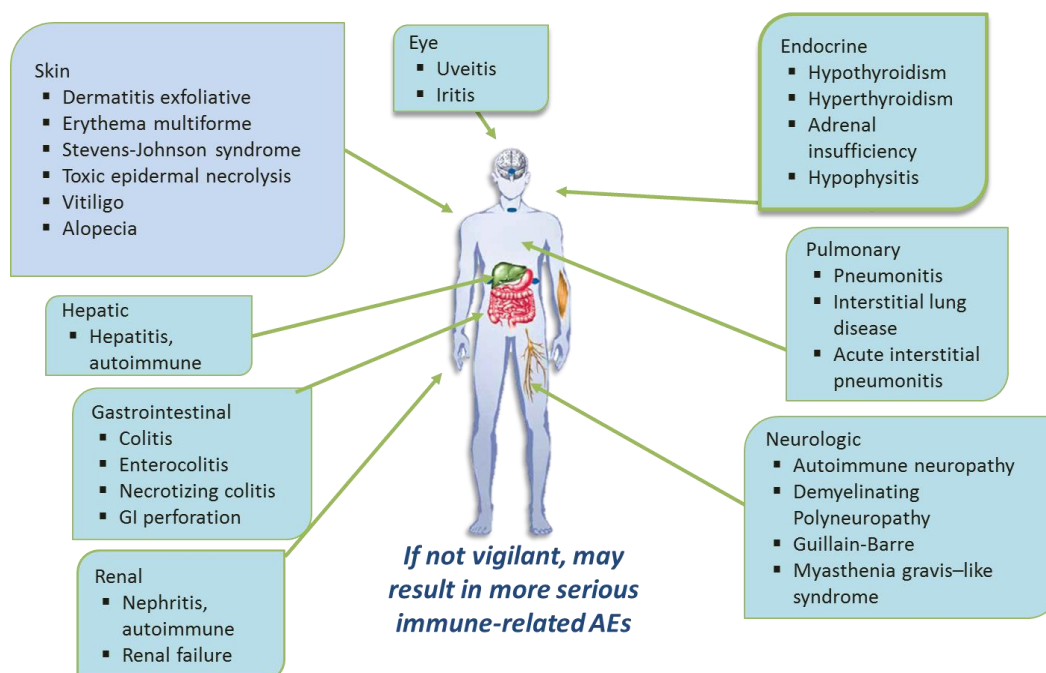
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Check this out - serious side effects

There is a range of **anti-cancer immunotherapy drugs** known as checkpoint inhibitors which are usually prescribed on a long-term basis e.g. up to 12 months or until disease progression. They act on the immune checkpoint proteins cytotoxic T lymphocyte-associated 4 (CTLA-4) and programmed death 1 (PD-1) and currently include **pembrolizumab, nivolumab, atezolizumab, durvalumab, ipilimumab** and **avelumab**.

- They are used to stimulate the immune system, which has shown a substantial improvement in the prognosis for a proportion of patients with selected cancers. They are currently licensed for use in some types of the following tumour groups: melanoma, lung, lymphoma, head and neck, urothelial and renal.
- Unlike traditional chemotherapy cycles, these immunotherapy products are used on a continuous basis.
- Their use is associated with a unique spectrum of side effects termed immune-related adverse events (irAEs), which can occur many months after treatment has stopped. These include:



- A recent MHRA [Drug Safety Update](#) also identified a risk of cytomegalovirus infection in patients on ipilimumab which may present as diarrhoea or other symptoms of colitis.
- It would be good practice to include in the Key Information Summary (KIS) that a patient has been prescribed one of these treatments and put an alert on the patient's records. They could also be added as an 'outside practice medication' following [Scottish Clinical Information Management in Practice \(SCIMP\) guidelines](#).
- The management of any suspected irAEs is complex, requiring specialist advice which usually includes immunosuppressive therapy. Patients will have been advised to contact the Cancer Treatment Helpline on **0800 917 7711**.
- Please report any suspected adverse drug reactions via the MHRA Yellow Card Scheme www.mhra.gov.uk/yellowcard
- **If you have any concerns regarding a patient on this treatment contact the oncall oncologist at the Western General Hospital on 07798 774 842.**

It's okay to be a quitter

Smoking and rheumatoid arthritis

The link between cigarette smoking and rheumatoid arthritis (RA) has been long established, with evidence suggesting that 25% of the disease burden is attributed to smoking¹. The risk of rheumatoid arthritis is increased two-fold in smokers of the equivalent of 20 cigarettes or more per day, when compared to "never-smokers"².

It has also been reported that patients who smoke are 50% less likely to respond to both conventional and biologic DMARDs (the first and second line treatments)¹. Although some patients may still benefit from treatment, the efficacy will be reduced compared to non-smokers.

The best way to quit is with both medication and behavioural support. With this in mind, the rheumatology service within NHS Lothian is working

jointly with public health services to pilot a new referral pathway which takes advantage of community pharmacy *Quit Your Way* services.

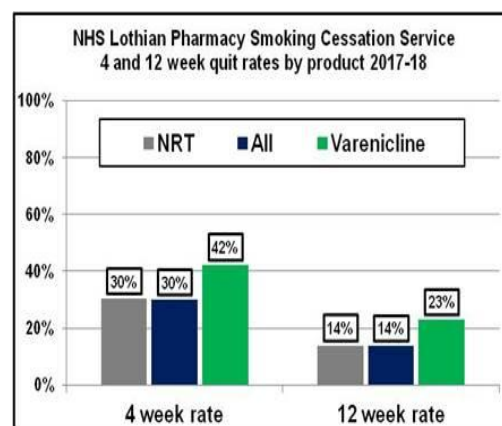
- A referral form is available in outpatient waiting areas.
- The form is completed by rheumatology clinicians following a discussion with their patients.
- Patients can take the completed form to a community pharmacy of their choice. This initiates the prescribing of nicotine replacement therapy (NRT) or varenicline plus behavioural support under a patient group direction (PGD).
- Community pharmacists providing treatment under a PGD will see patients weekly. They will be able to advise on potential side effects such as changes in mood or behaviour with varenicline.

What else is happening in NHS Lothian to help quitters?

- ✓ *Quit Your Way* is Scotland's free and friendly stop smoking services. It is provided locally in Lothian from every community pharmacy and also from *Quit Your Way* Lothian Services.
- ✓ Stop smoking services are part of a shared care model to offer the optimum way to quit smoking.
- ✓ Varenicline is now joint first choice in the LJF, along with NRT.
- ✓ **NHS Lothian is promoting *Smokefree* as a positive message**, and has implemented *Smokefree* NHS grounds legislation and *Smokefree* prisons legislation.

Did you know?

- When choosing between NRT or varenicline neither treatment has clinically relevant drug interactions (SPC)³ and varenicline was not associated with a significant increase in neuropsychiatric adverse events compared to placebo, as shown by the Eagles study⁴.
- Data shows that smokers are more likely to successfully quit using varenicline plus behavioural support. They are also nearly two-fold more likely to remain quit at 12 weeks, as shown in the adjacent graph.



Giving advice

Very Brief Advice (VBA) is minimum effort with maximum reward. It is very simple and takes 30 seconds to encourage smokers to attempt to quit.

- Ask – do you smoke? Are you still smoking?
- Advise – the best way to stop is with support and treatment
- Act – on patient's response to give information or refer⁵

References

1. Ash Scotland. Smoking and rheumatoid arthritis. <https://www.ashscotland.org.uk/media/4763/rheumatoidarthritis.pdf>
2. Giuseppe DD, et al. Arthritis Research & Therapy 2014; 16() <https://arthritis-research.biomedcentral.com/articles/10.1186/ar4498>
3. Champix Summary of Product Characteristics. <https://www.medicines.org.uk/emc/product/266/smpc>
4. Athenelli RM et al. Lancet 18 June 2016; 387:2507 -2520
5. Wright J. Guidelines in Practice. <https://www.guidelinesinpractice.co.uk/smoking-cessation/very-brief-advice-can-be-effective-in-encouraging-smokers-to-quit/337163.article>

Thanks to Eva Doolan, Mara Gilchrist and Kirsten Nicholson, Pre-registration Pharmacists, for contributing this article.

Oral Nutritional Supplements - best practice

Oral Nutritional Supplements (ONS) are sterile liquids, semi-solids or powders, which provide macro and micro nutrients and are used for individuals who are unable to meet their nutritional requirements through oral diet alone¹. ONS are prescribable for special medical purposes where Advisory Committee for Borderline Substances (ACBS) indications are met.

A review of ONS use across Scotland in 2016 indicated rising use, significant financial spend (over £16 million per year) and variation in clinical practice. This led to the development of [Guidelines for Appropriate Prescribing of ONS in Adults](#)² which NHS Lothian Dietetic Services are working to implement.

- In all settings, ONS should not be prescribed unless advised by a dietitian. A *Food First* approach should be the mainstay of treatment. [Supporting literature is available](#).
- [Homemade nourishing drinks](#) and over-the-counter products can be suggested for use whilst awaiting dietetic input or for those that fail to meet referral criteria.
- ONS may be of little benefit to patients nearing end of life or with substance misuse issues.

Guidance on appropriate management and referral criteria will be available on Ref-Help in the near future. Information regarding dietetic referrals for patients within hospital is available on TRAK under MUST in the Feeding and Nutrition section.

Collaboration between Dietetics and Pharmacy has resulted in the temporary recruitment of a number of Prescribing Support Dietitians. They will assist in

guideline implementation and clinical reviews of patients in GP practices and care homes to determine that:

- ONS remain clinically indicated and clear aims of ONS intervention are documented.
- If aims are not met within 3-6 months or patients fail to engage with dietetic follow up consider discontinuation of ONS.
- Those prescribed ONS meet [ACBS indications](#)
- ONS are in concordance with newly updated [LJF Section 9.4](#)

Contact Jackie Stevenson, Lead Prescribing Dietitian for further information.

Key messages:

- A *Food First* approach is first line treatment for undernutrition.
- ONS should only be prescribed under the guidance of a dietitian in both primary and secondary care.
- In most situations, ONS should be a short term treatment of 3-6 months to achieve aims.

References:

1. British Association of Enteral and Parenteral Nutrition (BAPEN) www.bapen.org.uk/nutrition-support/nutrition-by-mouth/oral-nutritional-supplements accessed Dec 2018
2. NHS Scotland Oral Nutritional Supplement (ONS) Short Life Working Group (2018) www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/08/Guidelines-for-appropriate-prescribing-of-Oral-Nutritional-Supplements-in-adults.pdf accessed Dec 2018

Fluoroquinolones - further concerning side effects

Recent studies have shown an increased frequency of aortic aneurysm and dissection in susceptible patients, following treatment with fluoroquinolones (e.g. ciprofloxacin, ofloxacin, levofloxacin and moxifloxacin)¹.

At risk patients include the elderly or those with:

- hypertension and atherosclerosis
- pre-existing aortic aneurysm or aortic dissection
- Marfan's syndrome and vascular Ehlers-Danlos syndrome
- Giant cell arteritis and Takayasu arteritis
- Behcet's disease
- family history of aneurysm

Use in these patients should be following a careful benefit-risk assessment and consideration of other therapeutic options. Patients should be advised of this potential adverse reaction and to seek medical attention if they experience sudden severe abdominal, chest or back pain. Remember to report any suspected reaction via the Yellow Card Scheme.

Other side effects of this class of drugs include tendon rupture and *Clostridium difficile* infections. The European Commission is due to consider the usage of these drugs in early 2019.

Reference:

1. [Drug Safety Update](#) volume 12, issue 4: November 2018

Changes for gabapentinoids

The Home Office recently announced changes to the legal classification of gabapentin and pregabalin. From 1st April 2019*, gabapentin and pregabalin will change from a Prescription Only Medicine [POM] to a Schedule 3 Controlled Drug [CD3]. The main implications resulting from this change are listed in the table.

Prescription writing requirements
<ul style="list-style-type: none">• patient name and address• prescriber name and address• drug name, strength and form• total quantity in words and figures• dated and signed• dosage instructions ('as directed' is not acceptable)• should follow requirements for CD instalment prescribing
Record keeping
Receipts and supplies DO NOT require to be kept in a CD register.
Storage
DO NOT require to be kept in a CD cabinet.
Validity of prescription
Prescriptions are only valid for 28 days from the date the prescription is signed or the appropriate 'start date' if specified, whichever is later.

A consensus document, supported by the Controlled Drug Accountable Officers Network (Scotland) Executive Group, provides [guidance](#) on some Frequently Asked Questions and additional information.

Controlled drugs are excluded from serial prescriptions via Medicines Care (and) Review, (*previously Chronic Medication Service (CMS)*).

*subject to Parliamentary approval

Thank you to Judie Gajree, Controlled Drugs Governance Team for advising on this article.

LJF Amendments: Antipsychotics and Contraception

Two sections of the LJF for adults have been extensively revised and updated - chapter 4, Central Nervous System and chapter 7, Obstetrics, Gynaecology and Urinary Tract Disorders. The main changes are summarised below but please refer to the LJF for full details.

Antipsychotics

- Amisulpride has replaced risperidone as a first choice antipsychotic for acute and maintenance treatment of psychosis. A reminder has been added to carry out baseline physical health checks before antipsychotics are prescribed, followed by regular physical health monitoring.
- Aripiprazole depot has been added as a second choice depot along with paliperidone to provide another second generation option. Tolerability with oral aripiprazole must be confirmed before the depot is started.
- Olanzapine or haloperidol are recommended as first choice for treatment of the acute phase of mania.
- Sodium valproate is no longer recommended as an alternative to lithium for mania or for maintenance treatment of bipolar disorder.

Contraceptives

- The recommendations for combined oral contraceptives have been revised and there is now a table of preferred products for use in primary and secondary care.
- Desogestrel and norethisterone are now first and second choice progesterone-only contraceptives respectively.
- Mirena[®] and Kyleena[®] are first and second choice hormone releasing intrauterine systems and Jaydess[®] has been removed.
- LJF choices for contraceptive diaphragms have been updated.
- Emergency contraception second-line choices have been revised to ulipristal (ellaOne[®]) or levonorgestrel (Emerres[®]).
- Prescribing notes throughout the section have been amended and revised. A new note is included in each section to give an indication of the efficacy of that particular choice of contraceptive.

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