LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

NHS Lothian

In this issue …

Issue No. 99 **September 2019**

LJF Update... LJF Update... LJF Update... LJF Update... LJF Update...

There has been a full review of the LJF infection recommendations in adults. This review incorporates recommendations from Public Health England (PHE), the Scottish Antimicrobial Pharmacists Group (SAPG) and other national guidelines for specific body systems. All agreed updates were reached following a consensus between the infection working group and expert representatives including public health, sexual health services and ophthalmology. The Infection chapter has been updated and anti-infective eye preparations in the eye chapter have been revised to align with changes. Please refer to the full chapters for details.

New prescribing notes have been added in the antiplatelet drugs section. Dual antiplatelet therapy may be considered in minor ischaemic stroke and in high risk TIA, if the risk of haemorrhage is low. Treatment is a loading dose of aspirin 300mg and clopidogrel 300mg on day 1 followed by aspirin 75mg once daily for up to 21 days. Then clopidogrel 75mg once daily to continue thereafter for secondary prevention.

In antidiabetes drugs, semaglutide has replaced dulaglutide as the preferred first choice weekly injectable glucagon-like peptide (GLP-1) agonist. Dulaglutide may be preferred if the patient has a needle phobia or dexterity issues as the needle is pre-loaded and hidden.

First line recommended hormone releasing intrauterine system for contraception has changed from Mirena® to Levosert®. Levosert® is also licensed for the treatment of heavy menstrual bleeding, but not for protection from endometrial hyperplasia during oestrogen replacement therapy. It is recommended to prescribe intrauterine devices by brand name in order to avoid any confusion.

Olaratumab

In issue 97 of the LPB we included an article on conditional marketing authorisation. We highlighted the example of olaratumab. The ANNOUNCE study to assess olaratumab (Lartruvo) in combination with doxorubicin in patients with advanced or metastatic soft tissue sarcoma failed to show a clinical benefit. The MHRA have now announced that the benefit-risk balance of olaratumab is therefore negative and the marketing authorisation in the EU will be withdrawn. Clinicians have therefore been advised not to start new patients on olaratumab and for patients currently on treatment, consider alternative treatment options. Available stock will expire in April 2020.

Farewell to Dr Simon Hurding

The editorial team would like to wish Simon all the best as he leaves his medicines management post and heads back to the coalface of general practice, for an exciting new venture. Simon's contribution to the prescribing bulletin and to medicines management is almost impossible to quantify – we will miss him greatly. Whilst Simon has been in post, there have been 156 editorial team meetings and 52 issues of the bulletin published. No photo this time, but who can forget the kilted photo when we welcomed him in issue 47. All the best Simon.

NHS Lothian COPD annual review template

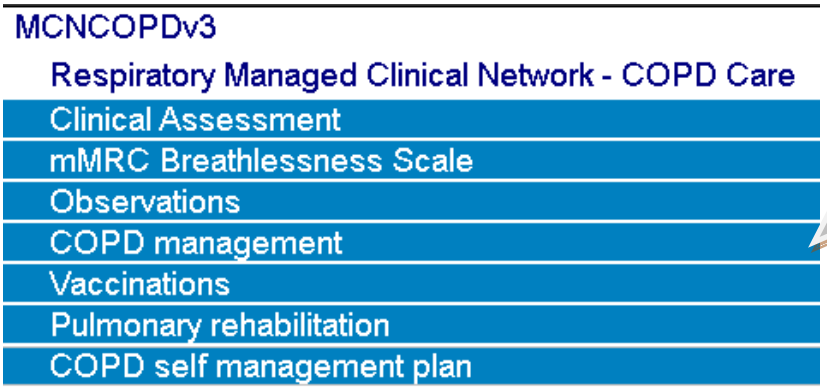
The treatment of chronic obstructive pulmonary disease (COPD) has changed over the years, with numerous new products now available on the market. To reflect the changes the respiratory Managed Clinical Network (MCN) has updated their guidance and developed a COPD Annual Review template based on the ref help COPD Care Annual Review Proforma.

This template is available for use in all GP practices using the software system VISION. It can be found under the **guidelines tab** and is called **MCNCOPDv3.** Options to upload the template to EMIS are being explored.

Advantages of the template:

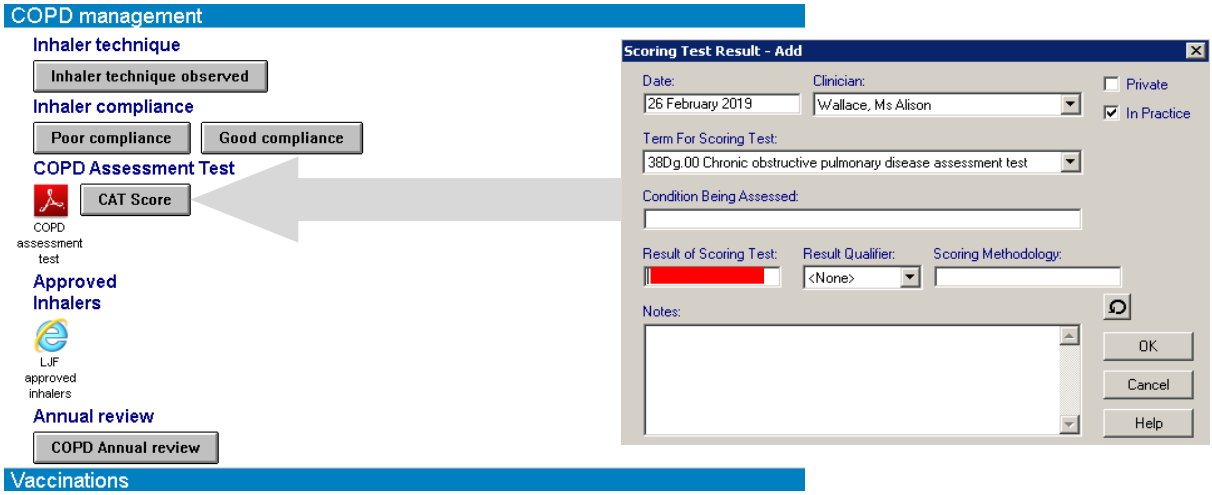
- All patients are reviewed to the same standard
- Data entered goes directly into the patient notes
- Easy to use and prompts staff
- Use of standard codes, enabling searches
- Integrated links to the LJF
- Option to print out advice for patients e.g. pulmonary rehabilitation information or self management plan

- Designed to flow like a consultation, the template improves coding consistency and formulary adherence. In line with the current guidance, it also features the revised mMRC Breathlessness Scale.



Each section of the template can be expanded to reveal headers and buttons to input data relevant to the section.

- Grey buttons within each section bring up pop-up boxes, allowing the user to record data and select the matching patient response from drop-down menus. These can also prompt discussions during the consultation e.g. a discussion around the flu vaccine, if the annual review is not at time of the flu season.



- The template is also equipped with clickable links to useful resources for reviewing patients. For example, the COPD Assessment Test (CAT) can be printed and the score recorded in the template. Patient friendly advice and information is also available via embedded links, such as pulmonary rehabilitation information and self management plans. It is recommended that this template is used for all COPD annual reviews performed within Primary Care in NHS Lothian.

Thank you to Lyla Moncrieff, Pre-registration pharmacist, at the time of writing, for contributing this article.

New drug driving regulations

On 21st October 2019 a new drug driving offence will be enforced in Scotland under Drug Driving (Specified Limits) (Scotland) Regulations 2019. This is in addition to the existing offence of driving while under influence of alcohol or drugs. The offence will cover driving with 17 specified illegal and prescription controlled drugs in excess of stated plasma levels.

- For drugs commonly associated with illegal drug misuse (including cocaine, cannabis, ketamine, heroin) plasma levels limits have been set close to zero to exclude accidental exposure.
- For prescription controlled drugs included in the legislation (clonazepam, diazepam, flunitrazepam, lorazepam, methadone, morphine, oxazepam and temazepam) the plasma limits have been set at a level where there can be significant impairment to driving.

The legislation includes a statutory medical defence which can be raised by a patient charged under the offence, provided the medication has been **legally prescribed** and taken in accordance with **verbal and written advice** from the prescriber/supplier.

What actions do healthcare professionals prescribing or supplying these medicines need to take?

Ensure that the patient is aware that:

- The specific medicine(s) may cause drowsiness and might impair driving.
- It is their responsibility to decide if their ability to drive has been impaired by the medicine and to take action accordingly.
- They can raise a statutory medical defence if charged under the offence.

The Scottish Government are developing guidance regarding the new offence for healthcare professionals which will be published in due course.

Blood glucose monitoring and driving

The DVLA recently updated guidance on appropriate glucose monitoring systems for drivers. Full details of the DVLA guide to insulin treated diabetes and driving is available at: A guide to insulin treated diabetes and driving.

Bus and lorry drivers (Group 2) must continue to use finger prick testing for the purposes of driving. Real time continuous glucose monitoring (RT-CGM) and flash glucose monitoring systems (FGM) are not legally permitted for the purposes of Group 2 driving.
Car and motorcycle drivers (Group 1) may now use finger prick glucose testing and FGM or RT-CGM for the purpose of driving.

As there are times when FGM and RT-CGM users are required to check their finger prick glucose, users of these systems must also have finger prick glucose monitors and test strips available when driving.

Drivers must not actively use FGM or RT-CGM or while driving a vehicle. They must pull over in a safe location before checking the device.

If using FGM or RT-CGM, they will need to pull over and obtain a confirmatory finger prick glucose level in the following circumstances:-

- Glucose level is 4.0mmol/L or below. The finger prick glucose level must be at least 5.0mmol/L before returning to driving.
- If they have symptoms of hypoglycaemia, are aware they have become hypoglycaemic or have an indication of impending hypoglycaemia.
- If the glucose monitoring system gives a reading that is not consistent with their symptoms.
- At any other times recommended by the manufacturer of the glucose monitoring system.

All drivers with insulin treated diabetes are advised to do the following:

- Always carry a glucose meter and blood glucose strips even if using a FGM or CT-CGM.
- Check glucose less than 2 hours before the start of the first journey and every 2 hours after driving has started (please note: more frequent testing may be required).
- If glucose is 5.0mmol/L or less, eat a snack. If it is less than 4.0mmol/L or you feel hypoglycaemic do not drive.

(For information, Freestyle Libre® is a flash glucose monitoring system.)

References

1. DVLA: A guide to insulin treated diabetes and driving (accessed 25th June 2019)

Not to be sniffed at - nasal saline and colds

The common cold is a viral upper respiratory tract infection (URTI) affecting much of the population each year, resulting in millions of lost work days for adults, and similar issues with days lost in education for children (and subsequent childcare problems for their parents).

Children can experience 6-7 episodes and adults 2-3 episodes annually[1]. URTI can also lead to more serious physical consequences such as lower respiratory tract infections or exacerbations of asthma, chronic obstructive pulmonary disease and cystic fibrosis. Prevention is thus desirable but also problematic as, while rhinovirus is 'the common cold', it is only one culprit amongst many different viruses that can cause URTI. This means that unlike other viral infections e.g. influenza, herpes, specific antiviral treatment is currently not available. Therefore, attention has returned to the use of saline in the form of nasal washes/sprays previously documented in Yogi manuals, a Lancet article in 1902 and studies in military recruits and Australian woodworkers.

The 2016 ENT UK guideline[2] gives saline washes a central role in treatment of chronic sinusitis but the NICE Clinical Guideline 79[3] is more cautious regarding its use in acute sinusitis, stating that there is not enough evidence to show nasal saline or decongestants help relieve congestion. With regards to side effects, systemic reviews of many studies have reported either no adverse effects or burning, irritation and occasionally increased rates of epistaxis, more often in association with hypertonic solutions and less so with isotonic solutions. There is some evidence to support its effectiveness in reducing symptoms of congestion and thick mucous making breathing easier, reducing the need for nasal decongestants. Large volume saline washes penetrate the sinuses better but nasal sprays are more portable and easier to use but probably require to be used many times daily to be effective.

ELVIS

Why nasal saline should work was explored in a pilot study, The Edinburgh and Lothians Viral Intervention Study (ELVIS)[4] expanding on work done in the 1960s, and corroborated by recent studies, which showed that chloride salts can inhibit viral replication by increasing intracellular hypochlorous acid levels. ELVIS was a small (68 participants) randomised control trial of hypertonic saline nasal irrigation and gargling (HSNIG) versus standard care in adults with URTI to gain initial information on acceptability of treatment, effect on duration of symptoms and viral shedding and the feasibility of a full trial. This study showed a shorter duration of illness (by 1.9 days), greater fall in viral shedding, lower use of over-the-counter medication, and fewer household contacts developing URTI in the intervention arm compared to the control arm. Most participants found the solution easy to prepare and use, and reported reduced nasal symptoms, reduced duration and severity of symptoms, and improved sleep. 60% would likely use HSNIG in the future, more (86%) if the procedure was more convenient. It was only a pilot study so not powered for efficacy endpoints thus a larger study is required to confirm the findings.

Additional information

- ENT section of RefHelp includes an information sheet on how patients can make a saline solution.
- The Childrens Hospital in Edinburgh are doing a study to see if saline nose drops help children get better more quickly. Children under 7 years of age can be signed up. More information is available at www.elviskids.co.uk.
- The LJF first choice product for nasal congestion is sodium chloride 0.9% drops.

References

1. https://dtb.bmj.com/content/57/4/56
2. https://www.entuk.org/sites/default/files/files/Rhinosinusitis%20commissioning%20guide%20%20for%20REPUBLICATION(1).pdf (accessed 7th Aug 2019)
3. https://www.nice.org.uk/guidance/ng79/chapter/Recommendations
4. https://www.nature.com/articles/s41598-018-37703-3

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