LOTHIAN PRESCRIBING BULLETIN

NHS Lothian

Supporting prescribing excellence - informing colleagues in primary and secondary care

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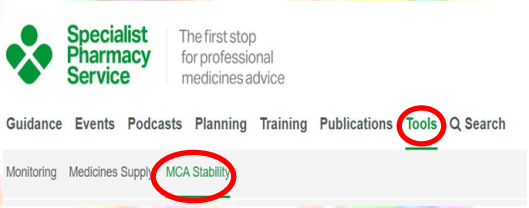
Blisters, dosettes or bubble packs... improved stability tool available from the Specialist Pharmacy Service and a new change form for prescribers to update community pharmacies!

Specialist Pharmacy Service

Information on the stability of tablets and capsules transferred from their original packaging into multi-compartment compliance aids (MCA) is available on the Specialist Pharmacy Services (SPS) website. Stability information had previously been available by searching under individual drug monographs. It has now been collated within the MCA Stability Tool.

Accessing the tool

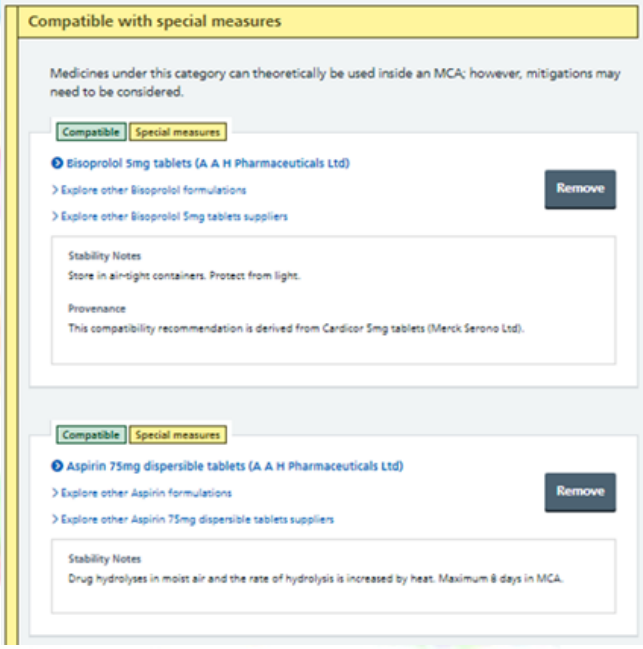
On the SPS website in the 'Tools' section via www.sps.nhs.uk/home/tools/medicines-in-compliance-aids-stability-tool. No login required.



How to use the tool

The tool is based on the DM+D structure, with new features that allow products to be added to a 'shopping basket'. The MCA Stability Tool allows you to search products and then build and print lists specific to your MCA; listing brand names, manufacturers, strength, formulation and a recommendation of suitability for use in compliance aids.

Stability notes provide additional information and mitigations where available. Where the word 'compatible' is used, this refers to the suitability of each individual medicine in MCAs.



How to communicate changes to community pharmacies from general practice

The General Practice Prescribing Committee (GPPC) agreed to the use of a standardised form to communicate compliance aid medication changes, to ensure accurate information is given to community pharmacies.

How to access the standardised form to communicate medications changes

Both electronic and hard copy formats are available on the intranet at: intranet.lothian.scot.nhs.uk/Directory/PharmacyServices/ClinicalPharmacy/Pages/DischargeAndCommunity.aspx.

What's in a name? When and how to prescribe by brand

Prescribing medicines by generic name is generally preferred but there are some circumstances when brand-name prescribing is warranted.[1,2]

Benefits of generic prescribing

- ⇒ Reduce risk of error as each drug has only one generic name
- ⇒ Quicker medicine supply as any suitable generic or branded product may be dispensed
- ⇒ Value for money as reimbursement is at a set price if the medicine is listed on the drug tariff.

'Branded generics' may have been given a brand name for marketing reasons or because there are clinical considerations to be made. List prices for branded generics may be lower than the list price for equivalent generics. However, these savings may be unsustainable by the manufacturer.[3]

When to prescribe by brand[4] (where examples are given, these lists are not exhaustive):

Bioavailability differences

Where bioavailability differs between brands and this is not specified on the prescription, then the patient could receive a sub or supra-therapeutic dose. *Examples: ciclosporin, lithium, CFC-free beclometasone metered dose inhalers, carbamazepine for epilepsy, metolazone.*

Release profile variations

Where some modified release (MR) preparations are not interchangeable because drug delivery may vary across brands. *Examples: diltiazem, nifedipine, methylphenidate.* Diltiazem MR - different versions of diltiazem MR preparations containing more than 60mg may not have the same clinical effect.

Specific device directions

When administration devices have different instructions for use and patients require training to use them. *Examples: adrenaline auto-injectors, dry powder inhalers, insulin injection devices.*

Biologics and biosimilars

The MHRA advises that biologic medicines, including biosimilar medicines, should be prescribed by brand name. *Examples: insulins, enoxaparin, erythropoietin, infliximab.*

Multi-ingredient preparations

Where products contain more than one ingredient, brand-name prescribing aids identification of the correct product. *Examples: pancreatin supplements, skin or scalp preparations.*

License variations

Generic preparations are licensed on the basis of bioequivalence with the branded product therefore brand-name prescribing should not be necessary. However, if license variations exist, prescribing by brand will facilitate prescribing within the license. *Examples: buprenorphine 400mcg sublingual tablets.*

Patient factors

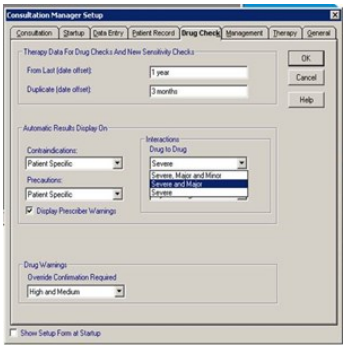
For some patients, differences in product name, presentation, appearance or taste may lead to anxiety, confusion, dosing errors and reduced adherence.

Useful resources

- The East Region Formulary (ERF) lists preferred preparations including favoured brands. The formulary also seeks to support consistent prescribing across primary and secondary care.
- Electronic Medicines Compendium
- Specialist Pharmacy Services
- How to Use Pharmaceutical Industry Medical Information Services

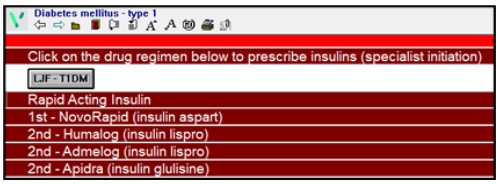
Primary care prescribing resources

Patient record systems, **Vision & EMIS**, display warning messages when prescribing medicines that have known associated risks to patient safety. *Please note*: **Vision** users will need severe and major warnings set up. This screen can be accessed in consultation manager. From the top bar select: CONSULTATION => OPTIONS => SETUP => DRUG CHECK



ScriptSwitch is used to promote safe, cost-effective formulary adherent prescribing. The messages displayed have different purposes: to support formulary prescribing, to encourage cost-effective prescribing or to highlight patient safety warnings issued by the MHRA.

eLJF-clinical can be used when prescribing for a clinical condition, showing formulary choices and prepopulated prescription options including, where appropriate, recommended brands.

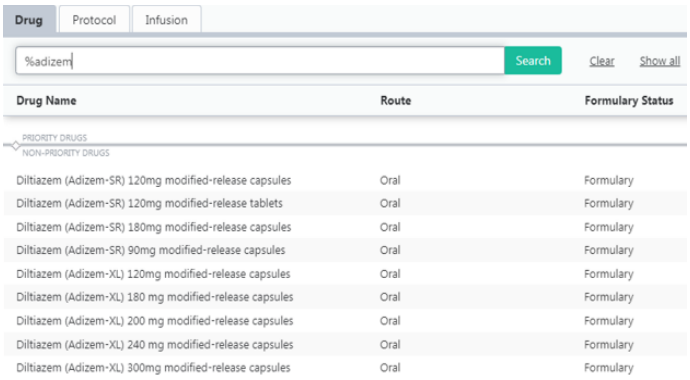


Secondary care prescribing resources

Outpatient prescribing remains paper based, therefore it is important to prescribe by brand where clinically indicated as described earlier.

On **admission to hospital** and where clinically appropriate, brand prescribing can be continued on electronic systems and this is recommended in the Golden Rules for Prescription Writing. The Emergency Care Summary (ECS), the patient and the patient's own medicines are useful resources to identify the brand that a patient has been prescribed in primary care as part of the medicines reconciliation process. This can then be populated on the HEPMA prescription chart.

Brands can be found on HEPMA by starting your search with '**%**' and then the brand name. For example, if a patient is prescribed **diltiazem** in primary care, the ECS will state the brand in the following format '**diltiazem (Adizem)**'. Then search '**%adizem**'.



There are two different preparations available. Adizem SR is a twice daily preparation and Adizem XL is a once daily preparation. When initiating treatment, the ERF recommendation is that once daily preparations should be chosen for patient compliance. The BNF or the clinical drug information tab on HEPMA provides information on the frequency and dosage regimen of each brand. Brand prescribing can be continued on discharge to primary care where appropriate and should be indicated on the Immediate Discharge Letter.

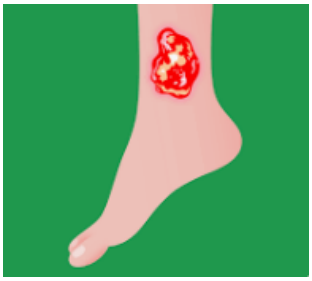
More HEPMA prescribing tips can be found on the HEPMA FAQ page on the intranet, or the HEPMA page on the NHS Lothian Medical Education webpage.

References

1. Prescribing by generic or brand name in primary care. www.sps.nhs.uk/articles/prescribing-by-generic-or-brand-name-in-primary-care
2. Generic medicines: European Medicines Agency. www.ema.europa.eu/en/human-regulatory/marketing-authorisation/generic-hybrid-medicines
3. NHS Lothian ADTC Position Statement. Prescribing of Branded Generics. policyonline.nhslothian.scot/Policies/Document/Prescribing%20Branded%20Generics%20Position%20Statement.pdf
4. Example medicines to prescribe by brand name in primary care: Specialist Pharmacy Service. www.sps.nhs.uk/articles/example-medicines-to-prescribe-by-brand-name-in-primary-care.

Red leg…what to do?

Antimicrobials and leg ulceration: To prescribe or not to prescribe…that is the conundrum?!?



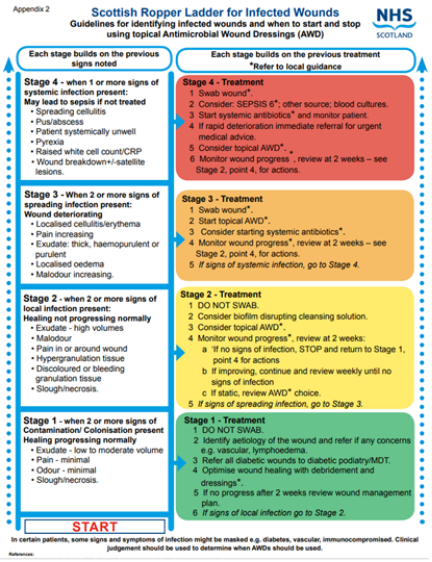
A one-year study across the UK beginning in 2017 noted that there were in excess of one million ulcers of the lower limb which represents 2% of the adult population.[1] Although most leg ulcers are colonised by bacteria, few are clinically infected.[2,3] If microbiology swab results are looked at in isolation without concurrent holistic assessment of the wound, there can be an incorrect diagnosis of a wound infection leading to the inappropriate prescribing of antibiotics. A further complication can be differentiating between venous disease and cellulitis because both can present with a 'red leg'.

In general, if a person presents with two red legs this is a strong indicator that their 'red leg' is caused by venous insufficiency rather than cellulitis. However some people can demonstrate venous insufficiency only in one leg and although very rare, bilateral lower limb cellulitis can present.[4] This list is not exhaustive and other differential diagnoses may need to be considered or excluded. Venous stasis in the lower limb will mostly require good skin care, topical steroid therapy, and early assessment for compression therapy.

Helpful tips

***Diagnosis and treatment**:* the Wounds UK Best Practice Statement on the holistic management of venous leg ulceration contains helpful tables to aid diagnosis and treatment.[4]

Guidance on wound infection stages and what level of topical antimicrobial/ antibiotic intervention is required is outlined in the NHS Scotland Scottish Ropper Ladder for Infected Wounds (2017)**.** This can be accessed via the Tissue Viability Intranet site and the ERF.[5,6] If wounds are at stages 1 and 2 of clinical infection, topical antimicrobial therapy in the form of a wound dressing or product is sufficient to reduce that bioburden. At stages 3 and 4 of clinical infection, systemic antibiotic therapy +/- topical antimicrobial therapy is indicated.


Appendix 2

Scottish Ropper Ladder for Infected Wounds

Guidelines for identifying infected wounds and when to start and stop using topical Antimicrobial Wound Dressings (AWD)

NHS SCOTLAND

Each stage builds on the previous signs noted	Each stage builds on the previous treatment *Refer to local guidance
Stage 4 - when 1 or more signs of systemic infection present: May lead to sepsis if not treated • Spreading cellulitis • Pus/abscess • Patient systemically unwell • Pyrexia • Raised white cell count/CRP • Wound breakdown+/-satellite lesions.	**Stage 4 - Treatment** 1 Swab wound*. 2 Consider: SEPSIS 6*; other source; blood cultures. 3 Start systemic antibiotics* and monitor patient. 4 If rapid deterioration immediate referral for urgent medical advice. 5 Consider topical AWD*. 6 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.
Stage 3 - When 2 or more signs of spreading infection present: Wound deteriorating • Localised cellulitis/erythema • Pain increasing • Exudate: thick, haemopurulent or purulent • Localised oedema • Malodour increasing.	**Stage 3 - Treatment** 1 Swab wound*. 2 Start topical AWD*. 3 Consider starting systemic antibiotics*. 4 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions. 5 *If signs of systemic infection, go to Stage 4.*
Stage 2 - when 2 or more signs of local infection present: Healing not progressing normally • Exudate - high volumes • Malodour • Pain in or around wound • Hypergranulation tissue • Discoloured or bleeding granulation tissue • Slough/necrosis.	**Stage 2 - Treatment** 1 DO NOT SWAB. 2 Consider biofilm disrupting cleansing solution. 3 Consider topical AWD*. 4 Monitor wound progress*, review at 2 weeks: a *If no signs of infection, STOP and return to Stage 1, point 4 for actions* b If improving, continue and review weekly until no signs of infection c If static, review AWD* choice. 5 *If signs of spreading infection, go to Stage 3.*
Stage 1 - when 2 or more signs of Contamination/ Colonisation present Healing progressing normally • Exudate - low to moderate volume • Pain - minimal • Odour - minimal • Slough/necrosis.	**Stage 1 - Treatment** 1 DO NOT SWAB. 2 Identify aetiology of the wound and refer if any concerns e.g. vascular, lymphoedema. 3 Refer all diabetic wounds to diabetic podiatry/MDT. 4 Optimise wound healing with debridement and dressings*. 5 If no progress after 2 weeks review wound management plan. 6 *If signs of local infection go to Stage 2.*
START	

In certain patients, some signs and symptoms of infection might be masked e.g. diabetes, vascular, immunocompromised. Clinical judgement should be used to determine when AWDs should be used.

References:

***Prescribing**:* NICE guidance on prescribing in leg ulcer infection is available as is the antimicrobial wound management section of the formulary. [2,3,6]

***Procurement of wound management products in primary care**:* procurement of wound management products in primary care, including antimicrobial products, is about to change shortly from a mainly prescription method to a more direct procurement route. There is currently no regular monitoring of antibiotics used in wound infection or topical antimicrobial wound management products within NHS Lothian. Practitioners are advised to follow guidance and adhere to the principles of good antimicrobial stewardship when reviewing and treating patients with these products.

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Thanks to Carol Jeffrey, Tissue Viability Clinical Nurse Specialist Quality Improvement, NHS Lothian