# PRIMARY CARE PRESCRIBER

***The monthly commentary on therapeutics for GPs, pharmacists, trainees, AHPs & community nurses.***

**April 2019**

NHS Tayside

*Prescribing updates written for Primary Care in NHS Tayside*

## Caring for care homes

### RPS Vision

The Royal Pharmaceutical Society have launched their vision putting residents at the centre of pharmacy care home services.

Their *report* has called for regular MDT medication reviews to improve the quality and safety of prescribing in the care home.

They highlight that care homes should have dedicated pharmacist time and residents should receive equity of access to community pharmacy services.

Interestingly they called for all care home pharmacists to be independent prescribers to properly support polypharmacy reviews and to be the first point of contact for all medication queries.

In line with local policy, all should be using original packs (and not 'trays'); beyond this they also suggest utilising electronic medicines administration charts.

There should be one GP Practice and one community pharmacy aligned to each care home wherever possible, and they state we should work to implement MCR (Medication Care and Review service) (the new abbreviation for CMS) into the care home setting.

This is all very ambitious. That said, mortality within 1 year of admission to a care home in the UK is *26%*. We must be cognisant of the potential futility of our prescribing and implement realistic prescribing.


## Target Drug

In this recent *study*—utilising the UK *CPRD network*, to which almost half of Tayside GP practices are *signed up!* - they found 51.2% of patients did not achieve the 40% reduction in LDL cholesterol (*NICE* say to reduce non-HDL cholesterol by 40%). The absolute reduction by doing so was 2.9 events per 1000 patients years (but relatively it's 22%!)

## Alternative

If we are going to prescribe a statin it may as well be at a dose sufficient to achieve the reduction of cholesterol which confers a 13% lower CV risk than those not getting to that target. Checking ALT and cholesterol is the only monitoring required for statins.

You'll likely need at least 40mg simvastatin, 20mg atovastatin or 10mg rosuvastatin—summarised LDL reduction tables can be found *here*.

## Medicines Complete

With *Medicines Complete* incorporating more resources for NHS staff, if you are accessing it from a non-NHS computer (at home) you will need an OpenAthens login—if you don't have one you can register *here*.

## Drug Safety Update

There are no safety updates for this edition.

## Formulary Update

MAG/ADTC was unable to support a formulary application for risedronate in the context of breast cancer. There are ongoing discussions with the relevant department to come to a consensus. There is no change in overall mortality from this, but confers about a 1% reduction in rate of distal recurrence.

Respiratory MCN Formulary group have reviewed their recommendations. Implementation plans are pending, but their review included removal of all LAMAs for COPD, removal of Ultibro® Breezhaler and switch of preferred ICS from Qvar® to Kelhale® (identical).

## How good is the drug?

A 77 year old lady sustains a Colles fracture and on DEXA scan has T-score of –2.1 (osteopenia). You are asked to start a bisphosphonate but the patient then asks what is the benefit..? *See page 3 for result.*

## Costs to note

*In this section we'll highlight some surprises, price drops, price increases and drugs coming off patent. Worth a search to see how many you might have on repeat...!*

Flixonase® (fluticasone) nasal spray £11.01 versus £7.26 for generic of same drug
Maxalt® (rizatriptan) melts £13.37 for 3 tabs versus £5.08 for generic of same drug
Switching both above could save £75, 842 per year.

## Spring has sprung!

In a brief summary of previously published advice, it is worth reiterating a few seasonal aspects to prescribing at this time of year.

Sunscreen is only prescribable to those with a photosensitivity disorder, vitiligo or genetic disease such as albinism. It is not prescribable due to allergy, eczema or previous skin cancers.

If a patient wishes their periods delayed (and they are not on the CHC as below) norethisterone will carry a similar VTE risk to the combined pill. As such, medoxyprogesterone 10mg TDS should be considered first line in line with ***TAF*** in particular for those who are at higher VTE risk (smokers, overweight, family history, long flight etc).

We generally should not provide more then 3 months supply of medication and should not provide a NHS prescription for travel related illness.

Hayfever is upon us with tree-pollens increasing rapidly in recent weeks. Almost all remedies can be purchased over the counter. There is little evidence of superiority of one product over the other although nasal preparations are probably more effective for most symptoms.. ***Nasal irrigation*** also gets a ***mention*** as a non-drug approach


### Ditch the pill-free period (now known as the hormone free interval)

In January the FSRH published their updated ***guidance*** on the combined hormonal contraceptives.

The traditional 7-day hormone free period is ***unnecessary*** and increases the likelihood of unintended pregnancy.

The FSRH have been clear that there is no health benefit to the usual 7-day break. Women can avoid any bleeding/cramps or other symptoms by not taking a hormone free period.

If a hormone-free period is taken, shortening it to 4 days can reduce the risk of pregnancy.

At the moment, there is not yet a 28 day pack available (all are still 3x21 day), but this may be coming to reflect the new guidelines.

For those interested in why we got to this point, the hormone-free period was never based on risks of harms from continual suppression but that having a monthly period might be "reassuring"... (the pill was ***devised*** by Gregory Pincus).

## Something of interest from the Journals...

This ***study*** interestingly affirmed the lack of benefit to aggressive blood pressure in those age >75. Patients with a SBP of >130mmHg showed less cognitive decline at 1 year versus those with a SBP of <130mmHg. The study alone is by no means conclusive but I think reflects actual practice.

We should also be mindful of further systematic reviews such as that just published ***here*** by JCEM.

Shared decision making is needed to allow a shared and honest discussion regarding the intended benefits of treatment, but also the unintended harms. When no one will live forever, we have to be honest what deckchairs we may be removing and which ones are left.

## How good is this drug?

A 77 year old lady sustains a Colles fracture and on DEXA scan has T-score of –2.1 (osteopaenia). You are asked to start a bisphosphonate but she then asks what is the benefit..?

As you might imagine, bisphosphonates/calicum/vit D are 'population' drugs. In this context if we assume the patient is a non-smoker and has no other risk factors for osteoporosis, there will be a ***1% reduction*** in absolute risk of a hip fracture and 6% reduction in any other fracture.

It is worth noting NICE have a useful ***patient decision aid*** for starting bisphosphonates. Calculate the ***QFracture*** risk and pick the appropriate Cates plot.

**NHS Tayside recently approved their *guidance* on managing prescription requests after a private consultation . There are some key messages to note particularly in relation to receiving a non-formulary suggestion. Please utilise your practice pharmacist and if needed HSCP leads if required. I am always happy to answer these queries as Angus colleagues will be aware.**

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*PCP is a commentary on therapeutics and policy. It is reviewed prior to publication, but isn't written as policy itself.*

## *Useful prescribing websites*

***Renal Drug Database*** (authoritative CKD drug dosing) Username/password via your practice pharmacist

***Safe for lactation*** (type the medicine name in the top search box)

***Anticholinergic Drug Burden*** (a useful calculator to add up cumulative anticholinergic burden)

***UKTIS*** (advice on prescribing drugs in pregnancy) [Hit **continue** at the warning.]

***BUMPS*** (patient leaflets for each drug in the website above)

***HIV drug Interaction Checker***

***Hepatitis Drug Interaction Checker***

***Syringe Driver Compatibility*** (Register for free and hit **SDSD** (4th tab at the top))

***Knowledge Network*** has links to Enteral feeding guide (can it be crushed via PEG?!) & Drugs safe in lactation book in the **Medicines Information Resources** section. Use an Athens login.

***TOXBASE*** Username/password given on registration. You can register the practice.

***Tayside Pharmacy Publications*** (Previous Tayside Prescribers, PCP and ADTC Supplements)

***The NNT.com*** The NNT for medications. It doesn't quantify the gain, but the NNT to get a benefit (which it itself might be small). The NNT also assumes an 'ideal' patient and again not bespoke to all.

*Tayside Medicines Information Centre TAY-UHB.medinfo@nhs.net or 01382 632351 will always help with prescribing issues covered on the websites above*