PRIMARY CARE PRESCRIBER

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

August 2019

NHS Tayside

Prescribing updates written for Primary Care in NHS Tayside

Medicines Shortages

Local considerations

It will not have escaped readers that the political winds are swirling as autumn approaches. With this storm, the possible issue of medicine supply shortages looms.

In what is more a coincidence than anything else, last week we received a *formal letter* from the Chief Pharmaceutical Officer highlighting current HRT shortages.

Primary care will struggle with capacity to manage the administrative and clinical burden that a significant increase in the volume of shortages could bring.

While the issues have been *well documented*, it still remains that 75% of all our medicine stock is imported from Europe. Beyond this, "because of short shelf lives... it will not be practical to stockpile six months' supplies" *leaked documents* report.

Beyond *MIMS* and *SPS* providing shortage updates where they can, *this update* from CPS affirms the suite of options already available to a community pharmacy in the event of a medicine not being available to dispense.

Pending "*Serious Shortage Protocols*" could help, but it will be at the frontline where our processes need to be seamless to manage the day to day parts of queries.

Switching to an alternative medication doesn't always help. Local management at practice level should be affirmed in good time.

Target Drug

30% of genital warts will spontaneously resolve by 6 months with no active treatment.

Topical podophyllotoxin cream was useful for warts not in direct line of sight, but is not available until at least April 2020.

There is an unlicensed special, but I cannot support the use of this alternative (it'll also likely be expensive!)

Alternative

Beyond doing nothing, warts in direct line of sight (usually penile warts) can be treated with podophyllotoxin solution.

For those not visible to the patient, cryotherapy remains a good option (and is the only option for pregnant patients). Beyond this imiquimod 5% cream is also green on *formulary* for this indication.

Local guidance can be found *here*.

Drug Safety Update

MHRA released a *safety update* on HRT, which received significant press coverage. Based on a *Lancet paper*, the BMS issued a *response*. Starting and continuing HRT should be a shared decision. Information to support this can be found in *local*, *national* and *GP Update* guidance.

NICE has released a *consultation* on cannabis based medicines. You can voice your opinion on this emotive topic until 5th September.

SIGN's updated Chronic Pain *guideline* expressly recommends a review soon after starting opioids and at least annually thereafter.

Formulary Update

The new *Overactive Bladder Pathway* was published and importantly recommends 3 months of non-drug options first line.

Please note the *Lyme Disease pathway* and *BNF* have Doxycycline 100mg BD for 21 days as the usual treatment duration.

Respiratory queries

A 66 year old female with COPD feels she has an increase in green sputum and asks for ciprofloxacin. When would you support this request?

See page 3 for discussion.

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...!

Tamoxifen 30 capsules: 10mg £41.39 versus **20mg at £4.87** versus 40mg at £48.72
Tramadol 60x 100mg MR caps £12.14 vs Marol® brand £6.94; 150mg generic £18.21 vs Marol® £10.39
Tramadol 200mg MR generic £24.28 vs £14.19 for Marol® brand.

Obstetric prescribing gems *[most are off-label!]*

The following is an extract from local Consultant Obstetrician, Dr Katy Orr's presentation to the GPST3 teaching on Obstetrics which I thought might be useful to share.

The most common teratogens are methotrexate, valproate, phenytoin, carbamazepine, warfarin, lithium, vitamin A analogues and ACE/ARBs. The later can be switched by us, otherwise refer early.

In management of nausea and vomiting there is guidance ***here*** [treatments on pg 25]. Add another medicine if symptoms are not controlled (don't always just switch) - don't forget IM route acutely.

For reflux, try alginates liberally, add in ranitidine 150mg BD; if needed it's safe to use omeprazole. For laxatives, Fybogel® first, then Senna®, docusate or Lactulose®.

Azathioprine, sulfasalazine and steroids are all safe. Biologics are usually stopped at 32 weeks. Tacrolimus is continued at lowest possible dose. TSH will always rise in first trimester. Locally the current advice is to increase T4 dose by 25mcg when the person becomes pregnant.

Avoid COX2 inh, NSAIDs can be used until 32w, aspirin is safe at doses <150mg/day and caution with opioids. Amitriptyline, betablockers, triptans can be used if needed for migraine. Sertraline is the safest antidepressant. Avoid oral fluconazole in 1st trimester; tetracyclines should always be avoided. UTIs management is described ***here***.

5mg folic acid in BMI >30, previous tube defect, antiepileptic drugs use or previous pre-eclampsia. Those at risk of pre-eclampsia will now start 150mg aspirin at night from 12 weeks.

NICE affirms the need to assess overall risk

NICE have boldly ***supported*** offering treatment for those with stage 1 hypertension with a calculated CV risk of >10% (previously it was 20%).

Given treatment of low risk-stage 1 hypertension (home BP average 135/85mmHg—150/95mmHg) is known to ***cause harm with no benefit***, it is critical to also calculate the overall cardiovascular risk to establish if there could be overall benefit.

Given this wider approach, there are many lifestyle and non-drug approaches to reduce overall risk to consider as well as medication. We know that health goals and preferences for treatment are not always aligned to our expectation, in particular in the ***elderly population***.

Although NICE provided a ***decision aid paper***, this falls short of what we need to support these complex decisions.

Something of interest from the Journals…

Facial seborrheic dermatitis is a common presentation in primary care and can be quite persistent and recurring.

Beyond the ***standard topical antifungal therapies***, there could be a number of non-medicine approaches worth considering as highlighted in ***this paper*** in *Dermatology and Therapy*.

The BJGP has published ***this interesting article*** looking at different methods of hypertension monitoring.

While participants were eager to attain CV risk reduction, self-management was by far the least preferred method of management.

Respiratory queries

A 66 year old female with COPD feels she has an increase in green sputum and asks for ciprofloxacin. When would you support this request?

Advice regarding the prescribing of fluoroquinolone antibiotics, particularly ciprofloxacin, has increased ***awareness of the risks***, notably including aortic dissection. Use of ciprofloxacin has been limited to acute bacterial prostatitis, and epididimo-orchitis. Following discussion with the pharmacy and ID teams, this restriction has been altered to allow use in patients with COPD or bronchiectasis who have culture proven pseudomonas aeriginosa within their sputum, at times of exacerbation. This change has now been reflected in ***local guidance***. Further updates on the treatment of pseudomonas in chest disease is in development.

*If you wish any further information on this, or any other area of respiratory medicine in Tayside, please **email**.*

Think you've got medical statistics sorted? Check your knowledge with this 2 minute quiz!

Written by: Dr S Jamieson, GP. Kirriemuir Medical Practice. Clinical Lead Prescribing, Angus HSCP. Medicines Advisory Group, Drug & Therapeutics Committee, Angus Representative 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 the safe 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