PRIMARY CARE PRESCRIBER

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

February 19

NHS Tayside

Prescribing updates written for Primary Care in NHS Tayside

Controlled drug changes

Gabapentinoids become controlled drugs

Responding to a national consultation, the Advisory Council on Misuse of Drugs have recommended that pregabalin and gabapenin become Class C drugs under the Misuse of Drugs Act (1971).

From April, both drugs will be reclassified as Schedule 3 controlled drugs (similar to tramadol) under Misuse of Drug Regulations (2001).

We should be clear to people prescribed these medications that the reason for this change is concern over misuse, diversion, addiction and associated harms.

Gabapentinoids have been prescribed prior to a fifth of drug related deaths in Scotland.

This change will also mean that it will be illegal to possess pregabalin or gabapentin out with an intended use as prescribed medicine and it will be illegal to buy or sell to others.

The prescriptions must be dispensed within 28 days of the prescription being signed and we can only supply 30 days of medication.

The prescription must also indicate total quantity to be supplied in words and figures and cannot be on CMS.

There will be a letter to practices imminently to provide supporting information for this change.

Target Drug

Prescribing of a LABA (long-acting beta-agonist) in asthmatics without an ICS (inhaled corticosteroid) *increases the risk of death*.

What's more, *research* shows that if you prescribe the ICS and LABA in two different inhalers, patients do at times stop the ICS and just take the LABA.

As such no national asthma guideline supports LABA prescribing alone in a single inhaler and this is in line with *MHRA advice*.

There are still asthmatic patients on LABA alone in Tayside. COPD patients can be excluded, but all asthmatic patients should be under active review. Consider trying without, but if needed, use a ICS/LABA inhaler in line with *TAF*.

Drug Safety Update

The MHRA have warned carbimazole *increases the risk of acute pancreatitis* and of *congenital malformations*. It should not be routinely used in pregnancy and women of child bearing age should be on effective contraception.

SGLT2 inhibitors have been flagged as a possible cause of *Fournier's gangrene* and if a reaction is suspected a *Yellow Card* should be submitted.

Emollients safety

MHRA have reiterated their *advice* on the extremely small risk of fire from paraffin-based emollients. An ointment exposed to a domestic naked flame can catch fire. However, creams/gels contain too much water to easily ignite.

Formulary Update

Sildenafil 50mg 3 times weekly is approved for post urosurgical erectile dysfunction. Methylprednisolone with lidocaine is also approved for joint injection.

How good is the drug?

A 75 year old female who lives independently at home with no additional osteoporosis risk factors is prescribed a calcium/vitamin D supplement.

What is the absolute risk reduction of any fracture over 2 years?

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...!

Losartan 25mg-100mg 28 tabs £4.50—£6.95 versus candesartan 8mg-32mg 28 tabs £3.99—£4.79

Mefenamic acid 500mg tablets £1.09/tablet versus 250mg capsules £0.18/capsule versus

Immunotherapy—things we should know

Immunotherapy is a rapidly evolving prescribing area in oncology with some important considerations for all clinicians (drug names end in –umab)

Known as checkpoint inhibitors, immunotherapy blocks the proteins made by cancer cells, which turn off your own immune system's destruction of the cancer. By 're-enabling' the CD8+T cells, your own immune system can then continue to be active against the cancer cells—this even after the therapy stops.

The list of approved treatments is increasing but includes melanoma, NSCLC, renal cell cancer, head and neck cancers, Hodgkin's and urothelial cancers.

They are not effective in every patient, but with ongoing effectiveness beyond the usual 2 years of therapy, they are more commonly being used.

Adverse effects are not as common as those seen in chemotherapy. Most reactions are caused by an overly reactive immune response so would include uveitis, skin reactions, hepatitis, nephritis, neuropathy, pneumonitis, colitis, arthritis and endocrine autoimmune diseases. The most severe type of reactions still occur in around 20% of patients. Most importantly, given the ongoing effects of the medication, an adverse effect should be considered in a presentation post treatment. Not all reactions will be clinically obvious, therefore a low threshold to check bloods seems prudent (FBC, C&E, LFT, TSH, cortisol, glucose , testosterone) (worth a 'yellow box warning in notes?)

The treatment for an adverse effect usually needs more than just stopping therapy (if still on it) and requires treatment of the condition itself e.g. oral steroids in case of a colitis.

Pitfalls and personal tips in acne therapy

There is a ***wealth*** of ***information*** available on acne therapy . There are some pearls in treatment—not all with brilliant evidence!

Comedonal acne (blackheads/whiteheads) will likely best respond to a topical retinoid—adaplene 0.1% gel or cream applied thinly at night. This should be avoided in pregnancy.

In moderate papular/pustular acne my preference is to go for a topical retinoid with benzylperoxide (Epi-Duo®). This leaves the door opened to add an oral antibiotic if required(lymecycline from age 12 onwards). Never co-prescribe topical and oral antibiotics (e.g. Duac® plus lymecycline) as this can increased bacterial resistance reducing treatment effectiveness. If lymecycline doesn't work, switch to Doxycycline 100mg daily. If very inflammed, start the antibiotic twice daily for a couple of weeks and then reduce to once daily (off-label).

'Trial-stop' antibiotics every 3 months (continuing topical treatment). If CHC is suitable to try Levest® first, and if no improvement after 3 months use *generic* Dianette®.

Something of interest from the Journals...

The ***Journal of the Endocrine Society*** published an interesting article highlighting the consideration for a more *realistic* approach to hypothyroidism in the elderly. They note a higher threshold of TSH prior to consideration for treatment with a natural increase in reference range with age.

Following on from the previous PCP article on medical cannabis use, this interesting ***article from JAMA*** highlights some of the issues with the increase use of cannabis extracts. Curiously 68% of cannabis oils purchased online are mislabeled.

As we all are aware, there is no such thing as a free lunch. Baby milk manufacturers are coming under increased scrutiny of their work supporting medical colleges/educational events as some suggest this may not be aligned to ***WHO guidance***.

With Royal Colleges under the ***spotlight*** for accepting sponsorship, the ***Lancet*** was also fairly robust in their commentary on this issue.

How good is this drug?

A 75 year old female who lives independently at home with no additional osteoporosis risk factors is prescribed a calcium/vitamin D supplement.

What is the absolute risk reduction of any fracture over 2 years?

For patients who are still living in their own home, the absolute reduction in fracture risk is at ***best 0.2%***. So 2 out of 1000 patients will benefit... Not great!

With ***data*** also showing an increase in CV events in those given supplements and notable ***published criticism*** of overdiagnosis in this area, we must be realistic in the gains we might attain from prescribing.

We do not know in a Scottish population if the relative vitamin D deficiency would confer a bigger gain, but either way this should be purchased by the patient in line with national ***advice***.

Ongoing thanks to Julian Treadwell of the Nuffield Department of Primary Care Health Sciences, Oxford for his ongoing questions in this area and we look forward to an open resource to help us all better articulate the intended benefits of medications.

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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