PRIMARY CARE PRESCRIBER

The monthly prescribing bulletin for GPs, pharmacists, trainees, AHPs and community nurses.

January 2018

Primary Care Services &

Medicines Advisory Group

Primary Care monitoring

What to check?

There's a dearth of any good evidence on which blood tests should be monitored whilst on a medication. Even for common heart failure treatments, a recent *review* highlights the lack of clarity on monitoring of renal function.

Another good example is warfarin: there is no recommendation to ever check FBC whilst on warfarin. Even though we have all seen patients with serious anaemia as a result. If a patient develops symptoms, we check a FBC.

This contrasts to newer Summary of Product Characteristics, which are now drifting towards screening for extremely rare consequences, without considering the potential harm from continually checking blood tests.

London Medicines Information Network has created a *PDF* with 'suggested' monitoring for *SPS*. This ISN'T something to be tied to—the evidence is poor/non-existent.

That said, it provides a starting point for discussion.

The most recent *SG guidelines* on Lithium Monitoring recommended ECGs every 6 months—there is no evidence for screening like this.

We must vigilant for symptoms which could be iatrogenic, but also avoid over-investigating and using up limited resources.

Target Drug

BuTrans® is the most popular brand of buprenorphine used.

Buprenorphine patches are *SMC approved* when used for moderate non-malignant chronic pain.

If a patch form of opiate is required in palliative care, fentanyl is *recommended*. In practice as the 'strength' of buprenorphine starts at a smaller equivalent dose, off-label use in cancer pain is not uncommon.

Alternative

Butec® is the brand of choice. Price differences are significant for an identical drug. It is the *Tayside Formulary* recommended brand. Generic prescribing is more expensive in this instance.

Drug Safety Updates

MHRA this month have *warned* prescribers that co-dydramol is now available not only in a 10/500 strength, but also now 20/500 and 30/500 formulations. It recommends dosing and prescribing instructions are clear to avoid risk of error.

All 3 strengths are **NON-FORMULARY** . Instead, TAF recommends co-codamol 8/500 & 30/500).

BNF Updates

No BNF updates to report this month

Formulary Updates

Pending DTC approval, MAG approved Accrete Once Daily Chewable tablet last month as the first line Calcium/Vitamin D Supplement.

It is the same price as taking Accrete D3 twice daily (£2.95 for 30 tablets of the once daily vs £2.95 for 60 tablets of standard twice daily).

It tastes good (I've checked!) and should be considered instead of the current Accrete D3 regime. However, It cannot be put in a weekly dispensing tray.

Costs to note

Surprises, price drops, price increases & drugs coming off patent.

Azithromycin 250mg 6 capsules £6.50 versus 250mg 6 tablets £4.38
Beconase® 200 dose nasal spray £2.63 versus Beclometasone (generic) nasal spray £2.51
Erythromycin E/C 250mg 28 capsules £5.61 versus 28 tablets £1.71
Keppra® Oral SF Solution 300ml £66.95 versus generic Levetiracetam Oral SF solution 300ml £5.63

Triple therapy inhaler

Triple therapy (LAMA/LABA+ICS) should not be used routinely in COPD and is reserved for those with moderate/severe disease who persistently exacerbate with FEV1<50%. It remains the least cost effective therapeutic option in COPD treatment.

Trimbow® (Chiesi) and now Trelegy® (GSK) are inhalers with LAMA/LABA/ICS. Both entered the market recently— Trimbow is progressing through local submission for formulary inclusion following SMC approval.

Trimbow® is a MDI and fits into an Aerochamber and is given as 2 puffs BD. Trelegy® is a dry powder inhaler one puff once daily.

They will cost less than giving 2 inhalers with ICS/LABA and glycopyrronium separately.

The ***TRILOGY*** and the ***TRINITY*** studies were used to firstly compare triple therapy to ICS/LABA alone and then in a 3 arm trial.

Inhaled steroids as part of triple therapy have been the subject of '***de-prescribing strategies***' in particular for those who have infrequent/no exacerbations.

There is no doubt, given the new inhalers are as cost effective as separate inhalers, compliance will improve. That said, the use should still remain confined to the minority with COPD.

Resistant UTIs

Last month ***Public Health England*** highlighted that the rate of trimethoprim resistant UTIs had increased—now sitting at 34% from 29.1% in 2015.

Although intriguing data, it has a few caveats. Nitrofurantoin isn't advised in renal impairment as a first-line alternative in all patients. The ***MHRA guidance*** on use of nitrofurantoin in CKD is useful.

Moreover local guidance on ***UTI treatment in CKD*** remains a good reference.

Moreover we don't know about resistance rates for those simple UTIs who are treated empirically without sending off a sample.

Resistance to nitrofurantoin remains low in samples sent to laboratories (only 3%).

In practice, I suspect we should consider nitrofurantoin over trimethoprim if we feel the patient is a higher risk of resistant growths (recent treatment/antibiotics).

Both remain suitable first line choices in the primary care population.

Something of interest from the Journals...

In primary care, many clinicians still perform incision and drainage of abscesses.

This is supported by ***NICE guidelines*** who suggested I&D for any significant fluctuant boils.

This month the Annals of Emergency Medicine has a helpful ***review*** exploring acute management of abscesses (with the assumption that they'll be incised). It explores questions such as the role of irrigation, covering with antibiotics and techniques for drainage.

A related issue of interest is cellulitis. Mastitis should be treated with co-amoxiclav or clarithromycin + metronidazole) if ***non-lactating*** or flucloxacillin if ***lactating*** - needle aspiration is preferred if an abscess forms.

Facial cellulitis should be treated with co-amoxiclav or clarithromycin).

Your ideas

With Scottish Government ***Guidelines*** now recommending almost universal vitamin D supplementation it makes you pause to consider if we should ever be checking levels? Or indeed if it should be a prescribable medication in deficiency?

The Scottish Government states all adults and children age> 5 take vitamin D, in particular from October to March. For fail/housebound patients it should be taken all year round.

Children age 1—4 should all be taking Healthy Start drops (or a commercial alternative) and from birth to 1 year supplemented if they take < 500mls of formula feed per day. The Government guidelines are clear that barring the agreed newborn supplements, people should pay for these OTC. This area is under review in NHST regards prescribed Vitamin D for treatment of deficiency. That said, I think public awareness of the recommendations is not significant. NHST still recommends OTC purchasing for maintenance therapy.

We should advise taking vitamin D as a routine health promotion recommendation.

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Useful prescribing websites

Renal Drug Database (CKD drug dosing) https://renaldrugdatabase.com/user/login Username/password via practice pharmacist or register.

Safe for lactation (type the medicine name in the top search box) https://www.sps.nhs.uk

Anticholinergic Drug Burden http://www.agingbraincare.org/uploads/products/ACB_scale_-_legal_size.pdf

UKTIS (prescribing information in pregnancy) https://www.uktis.org/html/maternal_exposure.html [only available 'off server'. Hit continue at the warning.]

BUMPS (patient leaflets for website above) http://medicinesinpregnancy.org/Medicine--pregnancy/

HIV drug Interaction Checker http://www.hiv-druginteractions.org/

Hepatitis Drug Interaction Checker http://hep-druginteractions.org/

Syringe Driver Compatibility http://www.palliativedrugs.com/ (Register for free and hit SDSD)

Knowledge Network has links to Enteral feeding book (can it be crushed?!) as well as other useful Medicines Information Resources http://www.knowledge.scot.nhs.uk/home.aspx

TOXBASE https://www.toxbase.org/ Username/password given on registration.

Tayside Pharmacy Publications (DTCs/Tayside Prescribers): http://www.taysideformulary.scot.nhs.uk/news.asp

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