PRIMARY CARE PRESCRIBER

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

Jan 19

Prescribing updates written for Primary Care in NHS Tayside

Why report using a yellow card?

Maintaining drug safety

The MHRA have made a concerted effort recently to increase the reporting of Yellow Cards.
They have launched a mobile App (on *Apple* and *Google*) which lets you submit a Yellow Card from your mobile device.
Reporting can also include medical devices, e-cigarettes, herbal and homeopathic products. It can also be raised by anyone including the patient.
There are particular *interest areas* including adverse drug effects in children, over 65s and biological medicines.
Although all drug reactions can be submitted, if the reaction is serious, it involves a *black triangle drug* or is an unlisted reaction we should be reporting this.
Users of Vision may note a prompt when stopping a medication due to an adverse effect. A video to demonstrate how to submit a Yellow Card from this is found *here*.
Whether it's via the *MHRA Website*, an App or on Vision, it is critical health professionals submit a Yellow Card if they suspect an adverse drug reaction. The system depends upon is all being willing to contribute and previous examples have proven this as effective.
The recent *reported risk* of Fournier's gangrene with SGLT2 inhibitors will depend upon Yellow Card reporting to identify cases.

Target Drug

Prescribers will note on ScriptSwitch there are prompts for all contraceptive pills. These all suggest switches to identical (but more cost effective) options. Desogestrol is the only generic switch, all others are brands.
Cilest® is noted in particular as Janssen Cilag have *intimated* they will discontinue manufacturing Cilest® in July 2019.

Alternative

Similar to emollients, contraceptives are high volume, low cost items and competition to provide more cost effective options is increasing.
TAF only suggests the generic drug, and we will endeavour to keep ScriptSwitch up-to-date to suggest the most cost-effective switch.
In this case Cilique® is suggested. (£4.65 vs £14.32 for Cilest®) [noting it's non-formulary as an aside!]

Mirabegron safety

Prescribers are reminded all patients on mirabegron *require* blood pressure monitoring prior to initiation and 'regularly' during treatment. It should be used in caution in BP >160/100 and is contraindicated in BP >180/110.

Drug Safety Update

Tapentadol (like many similar drugs) *can increase seizure risk*, in particular when co-administered with other drugs which lower seizure threshold.

Allopurinol

Last month we highlighted where allopurinol may be worth discontinuing for gout prevention. Lest we forget our primary care research colleagues who are using it for some (in slightly higher doses) in their ongoing *research*.

Formulary Update

GPs no longer need to prescribe fluoride toothpaste bar in head/neck cancers. Tayside dentists have agreed to be responsible for prescribing. Sjögren's is being considered as an additional GP prescribing indication.

How good is the drug?

55 year old smoker has a STEMI. Echo shows a normal LV. He is started on a beta-blocker. What is the absolute risk reduction of cardiovascular mortality at 2 years?

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...!

Procoralan® both strengths £40.17 versus £4.89 (7.5mg) / £6.58 (5mg) as ivabradine (generic)
Ropinirole 84x 5mg £184.67 versus 28x2mg £22.25

Sharing Care—Testosterone Therapy

The services delivered by primary care across Scotland continually evolve. Where some of our work stops—due to lack of evidence or moved to another provider— other work readily takes it place.

Testosterone therapy for hypogonadism in males has a recently updated ***Local Treatment Protocol*** including PSA monitoring requirements. (national Shared Care in transgender patients is pending).

The conundrum: prostate cancer is common when we go looking for it 40% of men over 60 and almost 60% over 80 have prostate cancer at autopsy —yet the prevalence is only 12.5% and mortality 7%.

Screening to avert testosterone driven progression of an indolent cancer will come with the acceptance we will find more cancer and increase the number of cancers treatments with the life-changing risks of treatment. For every 1000 men screened in the general population over age 55, 20 more cancers detected with no change in mortality. A useful poster is found ***here*** to explain this to patients.

We may have detection bias accounting for reported increase concern in this area. Multiple ***sources*** of ***evidence*** would advise any suggestion of causation is ***unfound***. Whether there is acceleration with testosterone therapy is difficult to assess and almost impossible to study.

BSSM Guidance suggests to check PSA annually as does the ***SPC*** (plus a DRE). Conversely ***guidance*** elsewhere says to check during year one then to discuss with the patient the pros/cons of ongoing testing. However, with high false –ve rates and false +ve rates an annual check doesn't provide full reassurance. Summary guidance on PSA testing, though slightly dated, can be found ***here***.

Is Champix® always safe?

Locally a significant portion of smoking cessation services is delivered by our community pharmacist colleagues.

Historically, prescribers were wary about a history of psychiatric disorder.

In 2016, the ***EAGLES study*** drew a fairly bold line under this. Notwithstanding the pharmaceutical funding source—which was the only way a study of this size was likely to be done—it produced fairly conclusive results disproving any of the previous concerns.

Given this, the warnings surrounding use in those with a psychiatric history have continued to be diluted, to the point where it can be provided by pharmacists as part of first line smoking cessation therapy.

The ***original warning*** was based on yellow card reports, but when reviewed via the ***GP Research database***, this case reporting was not supported.

Despite an update of ***MHRA advice*** and ***removal of black-triangle status***, the ***BNF*** still has a cautionary note, but this does not prevent general use.

Something of interest from the Journals...

We are continually being encouraged to review long-term opiate prescribing. The prescribing data shows we are making a difference with notable reduction in the past 2 years.

DTB have just published a useful ***summary*** of the current evidence to support this down-turn and to reinforce the underpinning justification.

Vitamin D seems to have yet another use...!

Researchers have concluded that it will reduce exacerbations in those who are deficient (1.23 vs 2.10 events per person per year; p=0.006). That's really good in terms of treatments for COPD...! As per Government ***advice***, we should all be taking it just now and if housebound should be taking all year round. As always it should be bought over the counter in line in Scottish Government ***advice.***

How good is this drug?

55 year old smoker has a STEMI. Echo shows no signs of heart failure and a normal left ventricle. He is started on a beta-blocker. What is the absolute risk reduction of cardiovascular mortality at 2 years?

This is not straight forward. We haven't really done the studies in a modern era where patients get stented/re-perfused etc within minutes of arrival into hospital. ***ISIS-1 trial*** (from 1986!) and the ***BHAT study*** (from 1982!) are two of a very small number of trials to show any short-term benefit for beta-blockers (0.7% and 2.3% CV mortality benefit respectively), which many subsequent ***trials*** have struggled to replicate. This is why we often don't see beta-blockers on discharge—we are then asked after clinic reviews to consider starting... If the LV was normal you may struggle to justify this.

Ongoing thanks to Julian Treadwell of the Nuffield Department of Primary Care Health Sciences, Oxford for focussing on this type of issue and we look forward to an open resource to help us all better articulate and understand 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