PRIMARY CARE PRESCRIBER

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

Jul 2018

Primary Care Services & Medicines Advisory Group

Should we anticoagulate with DOACs?

Should we always start…?

DOACs are the single most expensive class of medicines in Primary Care totalling about £2.3M/year For the same quality of prescribing, warfarin has a drug cost of £64K.

Being anticoagulated is a risk reduction intervention. Like quitting smoking, taking an antihypertensive or losing weight, it is not a 'treatment' or 'cure', it's a choice. With a CHA_2DS_2-VASc of 2, over a year, 983 out of 1000 people taking anticoagulation will have no difference in their outcome.

These *Cates charts* (from page 17 onwards) can help explain the benefits (and risks from page 29).

Importantly, accepting the caveats of a cohort design, this large UK based *review* showed those on rivaroxaban and lower dose apixiban had an increase all cause mortality versus warfarin… (edoxban data wasn't available as it was too new). None of the DOAC trials were conducted on a UK population and there are issues with study designs to make any fair comparisons.

Target Drug

There has been a near exponential increase in prescribed Vitamin D. NHS Tayside no longer supports prescribing for deficiency out with a disease e.g. In Osteomalacia in which case patients should be referred to endocrine. A new guideline is pending in TAF.

All people should be taking at least 10mcg (400iu) vitamin D. In lower risk people Oct-Mar, *higher risk* all year round. (costs £10.97 for a year *online*). On prescription it's £30+.

Alternative

Scottish Government are clear it should not be prescribed for purely seasonal/Northern hemisphere deficiency and should be purchased over the counter. If prescribed, InVitaD3® is the cheapest brand.

Drug Safety Updates

No MHRA updates of note to report.

BNF Updates

No BNF updates of note to report.

Formulary Updates

As noted, the criteria to prescribe Vitamin D have been amended. Unless deficiency has caused a disease, it is effectively a supplement which everyone should be on.

Lidocaine is moved to **AMBER** on formulary (secondary care initiation only). There remains a lack of evidence to support current level of prescribing. However there is agreement for use in: neuropathic pain initiated by acute/chronic pain team, renal and MFE. Palliative Care/Acute Pain team use for rib/sterna fractures remains unchanged.

Drug availability

Pinewood, the makers of emulsifying ointment have advised of a long-term supply issue. It contains SLS (sodium lauryl sulphate), an irritant in >50% of patients. The emollient formulary is currently being revised, but a switch to white soft paraffin 50%/liquid paraffin 50% is reasonable in this case.

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...!

Beclometasone nasal spray 50mcg £2.48 versus Beconase® £2.63
Timolol 0.50% eye drops £1.35 versus Timoptol® £3.12
Sildenafil 50mg £1.15 4 tabs versus tadalafil 20mg 4 tabs £2.00
Rosuvastatin 10mg 28 tabs £1.63 versus Crestor® 10mg £18.03

What's the safe dose for oral paracetamol?

Paracetamol continues be the foundation analgesia; that said we continue to see large meta-analysis concluding it is ineffective in ***osteoarthritis***, ***back pain*** and even for ***cancer pain***.

DTB have written an interesting article last month discussing the use of oral paracetamol in older people asking if we are using the correct dose.

People over 65 are excluded from many of the ***trials***, which makes confidence in the safety and efficacy more challenging.

Although as a single entity, ***NICE*** found no evidence to suggest reduced body weight is a justification to reduce the dose of oral paracetamol, it is probably a surrogate for frailty in older people. With this comes the risk of hepato-toxicity from concurrent respiratory, cardiac and renal impairment, co-administration of hepato-toxic medication, other liver disease and long-term effects of alcohol misuse.

DTB recommend we should adjust our dosing down to 60mg/kg/day which for those weighting 45-50kg (many older, frail people) would then be 2.7-3g/day.

This would be 1gram three times daily or 500mg 4 times daily.

The dosing of paracetamol is very commonly known, so it is worth specifically counselling patients/carers/family why you have given a lower dose. Acutely in short term use, in-patients do at times use full dose, even if known to be <50kg (with daily LFTs).

In addition, it is worth ensuring it is actually effective... Given the lack of evidence there is little point in taking the risk if it doesn't help or they are no better or worse without the medication.

Cranberry for recurrent UTIs

We await several updates on management of urinary tract infection from SIGN, Scottish Antimicrobial Prescribing Group (SAPG) and NICE..

The Cochrane review (2012) found no evidence to support the use of cranberry products in recurring UTIs. They did excluded a large outlying trial which showed benefit in non-pregnant females and the SAPG recommended use in their 2016 ***guidance***.

Local guidance on management of recurrent UTIs can be found ***here***, including advice on the use of methenamine.

Notwithstanding that all the guidelines are being revised, prescribers should be aware that 2 of the major manufacturers are discontinuing the making of cranberry products we commonly prescribe.

Nature's Aid cranberry 200mg tablet is still available and on Vision. That said, it is worth reviewing if it has worked prior to switching.

Something of interest from the Journals...

A ***systemic review and meta-analysis*** of 859 people with lower back pain and sciatica found that anticonvulsants (pregabalin, gabapentin or topiramate) were ineffective versus placebo.

They also found moderate to high quality evidence that the medications caused a high risk of adverse events (RR 1.4)

The review was fairly ruthless in inclusion criteria, but it does add to the weight of evidence to support safer non-drug options which may reduce pain without the adverse effects of medication.

Another publication of note was the ***Cochrane review*** on steroid duration for COPD exacerbation. They concluded there was not evidence to support any harm (or benefit) to a treatment duration beyond 5 days - the studies used a 30mg prednisone dosing.

This chimes with the most recent ***GOLD Guidelines*** which suggest duration should 'not be more than 5-7 days'

Your ideas

Some practices, and indeed groups of practices, have a standardised local approach to the prescribing of hypnotics, higher strength opiates and sedatives. This has commonly been advertised in reception rooms across a locality.

For all new patients joining a practice the poster may advise that: "Your GP will discuss with you about your problems and medication and consider safe and effective ways of reducing and stopping them whilst dealing with your problem in a different way."

Existing patients are advised, "It is very likely your GP will be discussing these prescriptions with you at some point soon."

Patients getting acute prescriptions are advised, "Your GP will work with you to ensure that you are on the lowest dose that works, with the shortest course possible."

This type of standardised approach across a Cluster could be very effective and it is clear in the Prescribing Indicator reports that a higher prescribing pattern can be turned around over a couple of years.

The poster in this case was from South East Angus.

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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