PRIMARY CARE PRESCRIBER

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

June 2019

NHS Tayside

Prescribing updates written for Primary Care in NHS Tayside

Preventing dementia

What can we do?

The management of dementia in the coming years will be a significant challenge for primary care with the *projected* 80% increase in prevalence over the next 17 years.

It makes sense to try to avoid accelerating cognitive decline by reducing use of anticholinergics. No less the associated *increase in falls, CV events and mortality*.

This recent UK general practice based study showed anticholinergics increased the number of patients with dementia by **10.3%** (if the association is causal).

Medications to reduce are anticholinergic antidepressants, antiparkinson and antiepileptic drugs, antipsychotics, bladder antimuscarinics and sedating antihitamines.

Moving to *lower anticholinergic burden options* (with *Scottish guidance* on page 37) - and non-drug options—should be actively considered routinely at medication review and in particular with symptoms of early cognitive decline.

Therapeutic indicators (online publication pending) will soon show your practice trend of strong anticholinergic prescribing in >75s. pQDIP can also show patients with dementia and on 2+ sedating/anticholinergic drugs, and a list of elderly pts on 2+ sedating/anticholinergic drugs depending on age.

Target Drug

With summer about to come (and go) in the coming weeks it is worth remembering there are set conditions for which sun cream can be prescribed.

The patient must have: an abnormal photosensitivity disorder (e.g. PLE, xeroderma pigmentosa or porphyria), vitiligo or chronic/recurrent herpes simplex labialis.

Alternative

Patients should otherwise be advised they do not qualify for sun cream on prescription. This includes those with an allergy to their purchased sun cream, if they have eczema or previous skin cancer. All should follow advice on this (9 page!) *booklet* or this lighter page from *NHS Inform*.

Drug Safety Update

MHRA have said if anticoagulation is needed in patients with antiphospholipid syndrome, warfarin (and not DOACs) should be used—DOACs have a higher rate of recurrent events.

Formulary Update

Ibandronic acid is accepted as an **AMBER** medication in *TAF* for use 2nd line in reducing the risk of distal metastases in breast cancer. This is until IV zolendronic acid is available as the first line therapy, which has most *evidence*. This confers about a 1.4% absolute reduction in risk of distal recurrence but has no change in all cause mortality. If patient is at risk of osteoporosis calcium/vit D could also be considered after a shared decision on their fracture risk.

We still await a finalised template shared care agreement for prescribing transgender medicines. Lothian colleagues are working on this to share nationally.

How good is the drug?

A 75 year old man is prescribed finasteride for BPH. What is the absolute risk reduction of urinary retention or needing prostate surgery?

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...!

Candesartan 2mg tablets 1 year supply £144 versus losartan 12.5mg tablets £40
Perindopril 2mg tablets 1 year supply £45 versus lisinopril 2.5mg tablets £12

Explaining risks

There is a significant amount of work ongoing nationally and more widely to help explain the benefits/risks of medications.

The era of guideline/QOF driven medicine has gone. Realistic ("Personalised") Medicine is a refreshing place to work.

Too long a misnomer, evidence based medicine became evidence *driven* medicine. Even if the effect was small (1 patient benefits in 400), both clinicians and patients accepted it was entirely ethical to treat all without much room for choice — without doing so we would never find the one person who might benefit. At times this may minimise the medication burden issues, side-effects or cumulative adverse effects.

Some patients might feel they wish to try this medicine, others may decline. We cannot impose our values of level of acceptable benefit, but find better ways to articulate this information and let patients choose.

A great example is the risk reduction benefits of anticoagulation—one of the best 'population' level medications.

SPARC TOOL is a great website to help explain the intended benefits/harms of anticoagulation. Age 75 with CKD, on aspirin for CHD found to be in AF. With anticoagulation you will reduce the annual risk of embolic event from 3.5% to 1.2%. At the same time you will take your risk of major bleed risk from 0.5% to 4.7%.

We cannot decide what a patient might feel is the right decision. However we do need tools to better explain the benefits/risks to patients (and clinicians!).

JIC medications

During OOH times (70% of the hours of the week) if JIC medications are deemed sensible to put in place, it can take up to 2-4 hours of GP/family time to source medication. It can also involve contacting and opening up a community pharmacy which can be time consuming.

Recommended doses of morphine for opioid naïve patients assumes we can rapidly review patients (which we can't), that another dose can be given within an hour (which it usually can't) and that the pain will be uniform in intensity (which it isn't).

It is worth noting 2mg morphine is less potent than taking 2x 30/500 co-codamol.

As such, the doses chosen must be cognisant of the anticipated level of pain, current symptoms, anticipated future need, any previous opioid use and likely timescales to repeated dose. (also consider doses for catastrophic bleed/seizures).

Dosing evidence to support the current doses in a UK primary care setting is disappointingly sparse!

Something of interest from the Journals...

DTB have ***published*** a useful review of this original ***paper*** regarding expected responses to antidepressants. Slightly contrary to ***NICE guidance***, DTB and the original authors feel it is worth holding out for the 22% chance of response by weeks 5-8 of therapy. There is a further 10% response rate at weeks 8-12. With NICE advocating switching at 3-4 weeks, this seems too early in light of this meta-analysis. (placebo has a 13% response rate by week 8 and a further 2.4% by week 12).

As we move towards pharmacotherapy, it is worth remembering this ***review*** showing discharging doctors do not reliably predict medication related harms (MRH) with 30% of >65 yr olds experiencing harm requiring intervention within 8 weeks of discharge due to MRH.

How good is this drug?

A 75 year old man is prescribing finasteride for BPH. What is the absolute risk reduction of urinary retention or needing prostate surgery?

According to this ***Cochrane review***, there is a 2.7% reduction in the risk of urinary retention and 3.6% reduction in the risk of needing prostatic surgery.

Ongoing thanks to Dr Julian Treadwell of the Nuffield Department of Primary Care Health Sciences, Oxford for his questions in this area and we look forward to an open resource he is working on to help us all better articulate the intended benefits of medications. His paper on this subject - which many Tayside GPs contributed to—is almost finalised for publication.

NHS Tayside approved their *guidance* on managing prescription requests after a private consultation . There are some key messages to note particularly in relation to receiving a non-formulary suggestion. Please utilise your practice pharmacist and if needed HSCP leads. I am always happy to answer these queries as Angus colleagues will be aware.

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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