PRIMARY CARE PRESCRIBER

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

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NHS Tayside

Primary Care Services & Medicines Advisory Group

Antibiotic prescribing update

An update and a new addition

The Tayside Primary Care Adult empirical treatment of infection guidance has been ***updated***.
Notable changes include:

- antibiotics should only be given in the community to those with a non-blanching rash in suspected meningitis (or if transfer is > 1hour)
- treatment duration is now only 5 days for tonsillitis and sinusitis .
- nitrofurantoin is first-line for uncomplicated UTIs (with notable ***exceptions***).
- Doxycycline 100mg BD for 7d is now first line for Chlamydia.
- There is new ***guidance*** on management of pre-septal/periorbital cellulitis. Treatment is co-amoxiclav/clindamycin. Differences between this and orbital cellulitis is summarised ***here***.
- There is also an ***update*** on management of facial cellulitis- for those with a dental/sinus (non-skin) source of infection should also be treated with co-amoxiclav/clindamycin

Additionally a new ***Paediatric Antibiotic Guidance*** document has been developed. This covers many conditions specific to children not covered in the main adult policy. There is specific guidance on scarlet fever, primary gingivostomatitis and links to some helpful leaflets.

Target Drug

B12 and folate are critical for preventing megaloblastic anaemia. There is enough B12 stores in the body of 2-5 years. Folate stores are much shorter (4 months).
Dietary deficiency is the commonest cause of folate deficiency. B12 deficiency can be dietary as well as pernicious anaemia. Other causes can be found ***here***.

Alternative

Given there are reversible dietary causes, B12 & folic acid should **only** be given to initially correct the dietary deficiency if this was the likely cause (and not one of the rarer causes). Dietary advice highlighting the foods of choice and suggested treatment regimes are ***here***.
The overtreatment of deficiency is worth avoiding as treatment is often given long-term with no review.

Drug Safety Updates

Hydrochlorothiazide is usually combined with an anti-hypertensive as a medicine. MHRA have ***warned*** of a higher risk of skin cancer for patients taking this medication long-term.
Sildenafil should be ***avoided*** during pregnancy due to the risk of persistent neonatal pulmonary hypertension. Though not commonly prescribed in females, it is increasingly used in digital ulcers for example. There are issues with this due to historic ***drug restrictions***, which have never been repealed in Scotland to allow prescribing for a broader scope of diseases, even though the ***indications*** have been extended.

Formulary Updates

Formulary now includes Adoport® (a brand of tacrolimus) and prescribers will begin to see this more commonly as it is now the first-line treatment in new adult liver/renal transplant patents instead of Prograf®. The switch of current patients has established ***tolerability***, but will be managed by secondary care to monitor levels. For other indications, changes should only be made in conjunction with secondary care.

How good is the drug?

56 year old diabetic male has a BP of 154/87. If we get BP to <140/90 what is the absolute risk reduction of stroke over 5 years? If we get BP to 120/80 what is the additional benefit? *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...!

Epimax® Oatmeal Cream 500g £2.99 versus Aveeno® Cream 600mls £6.47 [non-formulary]
Epimax® Ointment 500g £2.99 versus Epaderm® Ointment £6.26 [both identical contents]
Isomol® Gel 500g £2.92 versus Double-base® Gel £5.83 [both identical contents]

Cannabis takes a small step towards becoming a medicine

We are all likely to have all seen patients who are using cannabis products for controlling pain. It is very common in particular in palliative care. It is worth asking about this given the risk of potentiating prescribed medication.

More widely you will have been aware that the UK Government has reclassified cannabis-based products on 1 Nov 18 to Schedule 2 of the ***Misuse of Drugs Regulations*** (meaning they could be prescribed).

It will remain an unlicensed drug (and for the moment would be imported) and these restrictions will not apply to licensed drugs Sativex® for MS spasticity and nabilone for chemotherapy induced nausea/vomiting.

Prescribing can only be permitted on a named person basis by secondary care and approved by ADTC Chair/Medical Director with supply via secondary care.

This ***CMO's letter*** provides clear guidance. It states that cannabis-based products can only be used where there is "clear published evidence of benefit or [in] UK Guidelines".

Cochrane and ***RCP*** state they do not support the use for cannabis products for pain. Likewise in childhood epilepsy, the current ***guidance*** shows a lack evidence beyond Dravet's syndrome and Lennox Gastaut syndrome. With this, prescribing for the moment is not likely to be endorsed.

Control your blood pressure…

In this ***study*** published in JAMA reviewing 38,286 people, we are left in doubt if those with stage 1 hypertension merit treatment if they do not have another cardiovascular risk factor or established CV disease. (stage 1 is average BP 140/90-159/99). In these cases it feels like we are regarding hypertension as a risk factor and should be reviewed in the context of other factors. This aligns with a previous ***Cochrane*** review.

There was no improvement in rates of mortality or CV events between those who receive treatment and matched controls who did not.

However, treatment most certainly came with risks including syncope, hypotension, electrolyte imbalance and acute kidney injury.

As we do for starting a statin, we must begin to consider wider risk factors before commencing treatment rather than just the BP itself. (BP of course being best measured by an average of home blood pressures!)

Something of interest from the Journals…

Readers may have noted the ***MIR*** study, which studied adding mirtazapine to a SSRI/SNRI for depression. Both the primary end point of depression rating and secondary endpoints showed little/no improvement with adding mirtazapine. Where often we look to the prescription pad for something to help, it should be as easy to signpost to a non-drug option with evidence.

This large Finnish ***study*** highlights the risk of dementia in those prescribed benzodiazepine and related Z-drugs for those using for longer than 1 year. The OR was 1.06— so 5.7% of the cases of dementia seen may be attributable to exposure to these drugs. Though a small increase, it is worth highlighting this and considering using the ***deprescribing tools*** available.

How good is this drug?

The ***UKPDS 39 trial*** showed controlling BP to 140/80 would reduce stroke risk by 0.9%. Not a huge benefit alone, but there is also a reduction in mortality by 2.3% and rate of MI reduced by 2.4%.

There is no additional benefit in mortality or rates of heart attack to get tighter control to 120/80. There is however a tiny improvement in stroke risk—a further 0.9% reduction (as per the ***ACCORD*** study). Aiming for tight control even in a young diabetic will not likely gain any benefit for the individual patient and is a 'population drug'.

There are other quirks in diabetes prescribing, which are similarly driven at trying to attain population benefit, but which come with very real risks of medication for the individual. More to come in future editions...!

As previously cited, many 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 web resource to help us all better articulate and understand the intended benefits of medications which he is developing in the coming years.

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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