PRIMARY CARE PRESCRIBER

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

Oct 2018

NHS Tayside

Primary Care Services & Medicines Advisory Group

Conventional academic papers won't work

Does evidence need a rethink?

At this year's RCGP Conference, Dr Ben Goldacre's *speech* [*click to watch*] stuck a chord.

He highlighted the difficulties in the modern prescribing landscape. The trials we depend upon to make prescribing decisions bear little resemblance in some cases to how we are using the medications. For many decisions there is no consensus on treatment duration. Another good example was lack of consensus on the best 2nd line medication for type 2 diabetes.

His ambition—which he has struggled to fulfil - is, if there is a clear treatment choice, patients should be randomised to receive a possible treatment and followed up.

To continue to give treatments on a population scale where there remains significant uncertainty is not justified and possibly harmful.

He also spoke about his *alltrials* website to encourage publication of trial results and the fantastic prescribing resource *openprescribing.net*

His charismatic approach to evidence based care is admirable. We hope Scotland gets openprescribing.net in due course.

Target Drug

Oral diclofenac remains off formulary. Despite this, in Tayside we prescribed it 6338 times in the last year.

This *study* highlights a concerning risk. In the 30 days post administration compared to naproxen/ibuprofen and no treatment, diclofenac causes a significant increased risk of GI bleed, stroke, AF, MI and cardiac death.

Other drugs containing diclofenac (such as Arthrotec®) are also non-formulary.

Alternative

For those who tolerate NSAIDs, ibuprofen with paracetamol still leads the *analgesic league table* with the best NNT.

To give diclofenac without exhausting the alternative options and advising patients of the significant increase in risk is hard to justify.

Drug Safety Updates

-A reminder to prescribers that nitrofurantoin should not be used in people with known interstitial lung disease. Moreover, all patients using long-term UTI antibiotics should be reviewed in line with previous *evidence*.

-EMA have strengthened their *recommendations* to discourage quinolone use. This guidance is in line with current Tayside antibiotic guidance.

-DOACs continue to gain some adverse evidence. After being shown to have an increased *all cause mortality* in AF, the MHRA just stopped this *trial* when DOACs used post-operatively again increased all-cause mortality.

-MHRA have warned again about the dangers of fentanyl patches—it's worth reading through their *advice*.

BNF Updates

Pregabalin and gabapentin will become *class C drugs* from April 2019. They will have the same prescribing constraints as tramadol.

Formulary Updates

Frovatriptan is now first line treatment for preventing menstrual related migraines on *TAF* taken from 2 days before until 3 days after bleeding starts.

How good is the drug?

66yo male, CKD 3A (no proteinuria) & hypertension on a CCB. BP 130/75mmHg. What is the ARR for adding ACEi for CV events & ESRF?

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...!

Neomag® 4mmol 50 tabs £22.77 (licensed form & formulary choice) vs magnesium glycerophosphate - variable cost

Nacsys® 600mg £5.50 (formulary choice) versus acetylcysteine 600mg £89.50 (identical)

The risks of addiction

Public health colleagues strongly ***advocate*** e-cigarettes as an option for adults to reduce their dependency on tobacco cigarettes.

However, the increase use in e-cigarettes may come at a price. V2 Cigs® (the UK's ***most popular brand***), is owned by ***VMR products*** who are in turn owned by ***tobacco companies***. This is a widespread ***pattern***.

There is growing ***concern*** surrounding the harm from the high concentration of nicotine in these alternatives which could potentially be more addictive than cigarettes. In a novel, less regulated market, a new generation are becoming addicted to a product with clever marketing and no long-term outcome data.

Akin to the previous work done by tobacco companies, there has been extensive ***research*** to maximise the efficient delivery of nicotine by e-cigarettes.

The ***evidence*** to support long-term adverse effects from nicotine addition are well known—in particular the contribution to cognitive decline.

Where cigarette alternatives do have the potential to help adults quit smoking, novel, high-tech, flavoured devices, which are available to purchase easily ***online***, are lacking the regulation to turn one harmful addiction into another for a new generation with unknown long-term outcomes.

Withdrawing antidepressants

In contrast to current practice and ***NICE guidelines***, a recent ***systematic review*** suggests withdrawal symptoms from antidepressant medication are common and can be prolonged. As a result it is likely that we are misdiagnosing symptoms of withdrawal with those of a depression relapse. This is likely causing increased duration of antidepressant use and may account for the continual increase in anti-depressant prescribing.

The review estimates the most severe intensity withdrawal symptoms in approximately 46% of people taking antidepressants with symptoms on average reported by 56% of people.

The duration of symptoms is often more than 2 weeks and can be more than several months in duration. (40% of people experienced withdrawal symptoms for more than 6 weeks!)

Patients must be advised of this risk and on reducing antidepressants be advised these symptoms will resolve, but it will take time.

Something of interest from the Journals...

Cochrane have concluded there is **no place** for antibiotics in treatment of acute rhinosinusitis. With antibiotic resistance and very low chance of severe complications they feel this is justified given half are better by 1 week and 2/3 better by 2 weeks with no treatment. 5-11/100 may be cured faster with antibiotics, but 13/100 experience side effects.

Next the ***Journal of Pediatrics*** have reviewed the evidence for oral corticosteroids in wheezy children. It is not uncommon to use oral steroids in wheezy children—in particular in OOH. In this review the authors highlight the lack of any evidence to affirm the role for steroids in particular in the home/outpatient setting.

Lastly to palliative care where this ***study*** reviews the role of hyoscine butylbromide for excessive secretions. Respiratory secretions at the end of life are distressing. In this review, prophylactic use is strongly advocated to improve efficacy over being responsive to symptoms as they develop.

How good is this drug?

Dr Julian Treadwell contacted me to express his thanks again for the fantastic contribution of Tayside GPs to his research on the perceptive benefits of medications. In tribute to this, we will take a similar approach once a month to ponder the value of medications both from his questions and beyond.

As Ben Goldacre pointed out, trying to quantify the benefits of a medication is difficult when the studies are not conducted on our typical multimorbid patient and continued indefinitely. That said, Julian is eager we find a modality clinicians can readily access to quantify the benefits of medication from what (limited) evidence we do have.

In the coming months I will also be writing guidance to help clinicians explain to patients the intended benefits of medicines as part of the Angus HSCP *Value your medicines* project.

Back to the question from page 1. If you are normotensive with CKD3 and no albuminuria there is **no benefit to an ACEi at all**. There is no reduction in progression to end stage renal failure nor CV events. This is consistent with ***international guidance*** and ***NICE recommendations***. Thereafter if you develop albuminuria with CKD 3B/4 there is significant benefit to prevent progression to end stage renal failure (ARR of 5% over a couple of 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 & lactation) [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 pregnancy & 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