Shared care guidelines

Start date: March 2017 Review Date: March 2019

Drug	AZATHIOPRINE/6MERCAPTOPURINE
Specialty	GASTROENTEROLOGY
Indication	Severe acute Crohn's disease, maintenance of remission of Crohn's disease or ulcerative colitis (unlicensed indication – BNF section 1.5.3)
Overview	Azathioprine/6Mercaptopurine is an immunosuppressants, often used as a steroid-sparing agent. Marrow suppression and liver toxicity are the main cautions.

Hospital specialist's responsibilities

Initial investigations: FBC, CRP, U&E, LFTs, TPMT, Varicella Zoster Immunity, pre treatment counselling with IBD nurse/consultant

Initial regimen: Azathioprine 2-2.5mg/kg/day 6Mercaptopurine 1-1.5mg/kg/day(may be adjusted according to TMPT status)

Clinical monitoring: For adverse effects and usual disease management
Frequency: As required, typically every 3-6 months once stable

Safety monitoring: FBC, ESR/CRP, U&Es,LFTs weekly for 6 weeks, then fortnightly until dose stable for 6 weeks; thereafter monthly.
Check FBC & LFTs two weeks after dose increase; thereafter monthly.

Prescribing and monitoring details: Minimum of 3 months from hospital then transferred to GP

Documentation: Clinic letters and results to GP. Separate patient information.

GP's responsibilities

Maintenance: Azathioprine 2-2.5mg/kg/day 6Mercaptopurine 1-1.5mg/kg/day
As advised at transfer

Clinical monitoring: For adverse effects & usual management
Frequency: As required and determined by patient symptoms

Safety monitoring: FBC, ESR/CRP and LFTs – monthly.
U&Es - 6 monthly

Check FBC & LFTs two weeks after dose increase; thereafter monthly

Treatment duration: Long-term as recommended by specialist

Adverse events

Adverse Event	Action required
WCC ↓ <3.5x10^9/L or Neutrophils ↓ <2.0x10^9/L or Platelets ↓ <150 x10^9/L	Stop azathioprine/6MP, repeat FBC & discuss with specialist
Lymphocytes < 0.5x10^9/L	Withhold azathioprine/6MP & discuss with specialist
MCV > 105	Check B12, folate and TSH. If normal, discuss with specialist
AST and/or ALT↑ >2 x ULN	Withhold azathioprine/6MP, repeat LFTs & discuss with specialist
Sore mouth / mouth ulcers	Check for other causes e.g. ill-fitting dentures. Prescribe Difflam mouthwash after meals and Nystan oral suspension for one week, then review and discuss with specialist
GI disturbance	Consider dose reduction &/or anti-emetic. Discuss with specialist
Skin rash, itchiness	Check for other causes (change of soap etc.). If mild, continue and review. If severe, discuss with specialist
Bruising/severe sore throat	Stop Azathioprine/6MP, check FBC and discuss with specialist

See overleaf

Other information

Contact details

Gastroenterology Dept, JCUH, Marton Road, Middlesbrough, TS4 3BW Telephone:01642 850850

Dr Hatim Taha	Dr Helen Dallal	Dr Andy Douglass	Dr John Greenaway	Dr Zorana Suvakovic	Dr David Oliver	Dr Arvind Ramadas	Dr Vikramjit Mitra	Linda Jolly IBD nurse
Ext 54860	Ext 52416	Ext 54846	Ext 54969	Ext 54476	Ext 54865	Ext 54860	Ext 54476	Ext 52462

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Further Information

Azathioprine (Gastroenterology)

Monitoring

FBC, CRP/ESR & LFTs – Monthly
U&E- six monthly

Note: Please watch for a falling trend for blood counts and rising trend for liver enzymes. Action may need to be taken even if the values are in normal range in these scenarios.

Vaccinations

Live vaccines in general are not recommended with Azathioprine, although the live shingles vaccination is appropriate in some patients (refer to Green Book for advice).
We recommend annual Flu vaccination.
Before considering the administration of any other vaccinations both the Green Book – Immunisations against infectious disease and the vaccine SPC are consulted.

Infections

Varicella zoster Immunoglobulin to be given to non-immune patients exposed to chicken pox

Fertility issues

Family planning and pregnancy should be discussed with either the Gastroenterologist or IBD nurse. In general, the greatest risk to mother and foetus during pregnancy is active IBD, and not the medication used to treat it. Azathioprine is categorised by the FDA for drugs in pregnancy as D, positive evidence of risk but risk/benefit ration should be considered.

Important drug interactions

ALLOPURINOL - serious risk of marrow toxicity. Azathioprine dose should be reduced to 25% of the original dose.

WARFARIN – anticoagulant effect may be reduced requiring an increase is dose of warfarin.

CO-TRIMOXAZOLE & TRIMETHOPRIM – increased risk of haematological toxicity

Thank you for sharing the care of this patient. The medical and nursing staffs in the department of Gastroenteology are happy to answer any queries your staff may have concerning the patient's treatment or any adverse events.

If you are contemplating discontinuing treatment please discuss with the Consultant or staff first.

If a patient has any problems with their medication, adverse effects or an exacerbation of their disease requires an earlier review then please contact the IBD nurse or the Gastroenterologist responsible using the contact details over.