NHS Cumbria Clinical Commissioning Group

PRESCRIPTION PAD

The Newsletter of the Cumbria Area Prescribing Committee

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Clinical Policy and Formulary News

Vitamin D guidelines

An updated Cumbria wide guideline on the management of vitamin D deficiency and insufficiency has been produced in response to feedback from primary care to provide clarity in testing, treatment, licensed preparations and promotion of self-management with OTC products.

Additionally, since the publication of the PHE Guidance (2014) – 'Increasing Vitamin D Supplements in at Risk Groups,' there are serious concerns of escalating prescription issues and test requests.

Nationally, GP prescribing has increased by 40% since 2012 to an annual cost now of £41m and GP requests for testing have risen by 115%. In Cumbria during 2015/16 a total of 155,000 items of vitamin D were prescribed at a cost of £645,000, averaging a monthly cost across the county of £54,000. NCUHT processed around 10,000 samples at a cost of £150,000/year (£15/sample), averaging £12,500 each month in North Cumbria alone. At the current rate of increase, the numbers of samples requested are predicted to double in the next 12 months.

New information is provided in the following areas to support a more rational and cost-effective approach to the management of vitamin D deficiency:

- **When to test/not test –** routine testing is NOT indicated. Vitamin D is not a helpful test in the investigation of tiredness, chronic fatigue/fibromyalgia or non-specific aches and pains.
- **When to re-test** - repeat tests will be blocked within 12 months unless justification is detailed on request form or discussed with biochemistry
- **Evaluation of calcium intake** - use of calcium calculators; review of co-prescribing calcium; avoid expensive combinations e.g. calcium and ergocalciferol
- **Prescribing in special patient groups** – renal disease, pregnancy, Halal and Kosher diets
- **Referral to secondary care**
- **Prevention** - PHE published (July 2016) new recommendations on vitamin D after the Scientific Advisory Committee on Nutrition (SACN) reviewed available evidence:
    - Birth-4 years, pregnancy, breastfeeding and the at risk population are recommended to supplement with 400 units of vitamin D all year round and 4 years-adult in the winter months.
- **Licensed colecalciferol product list** - the most cost-effective treatment options are below. These can be prescribed generically now they are listed in the Drug Tariff; only licensed preparations will be dispensed.
    - InVita D3 50,000 units/ml oral solution, once weekly for 6 weeks (6 ampoules - £12.50)
    - Colecalciferol 40,000 unit capsules, once weekly for 7 weeks (7 capsules - £10.50)
    - Colecalciferol 20,000 unit capsules, two each week for 7 weeks (14 capsules - £13.50)
- **Products available without prescription** – Healthy Start and OTC supplements. Self-management is strongly encouraged for the prevention of deficiency

	• **FAQ's** regarding prescribing
	• **Traffic Light Classification changes:**
	  • IM Ergocalciferol has RED status
	  • Treatment of vitamin D deficiency in children has an AMBER status
	
	The full guideline is comprehensive and intended as reference, so a summary of key points and a quick guide algorithm have been produced and can be found at: http://medicines.necsu.nhs.uk/guidelines/cumbria-guidelines/

Memantine and acetyl cholinestersase inhibitors in combination shared care guideline	A shared care guideline to support prescribing of memantine in combination with acetylcholinesterase inhibitors in primary care has been produced. A small cohort of patients responds well clinically to a combination of an AChEI and Memantine long term and deteriorates when either drug is decreased and/or withdrawn. The benefit is assessed either by a reduction in the rate of cognitive decline or by a reduction of psychological and behavioural symptoms. These patients may require continuous treatment with an AChEI and Memantine in combination. This guideline addresses this group of patients. During cross taper from an AChEI to Memantine it may be necessary / appropriate for some patients to temporarily be prescribed an AChEI and Memantine simultaneously, with the aim of discontinuing the AChEI and continuing with Memantine as monotherapy. In other patients, depending upon their clinical presentation, discontinuing an AChEI straight away before commencing Memantine may be appropriate, particularly if it appears the AChEI may be exacerbating distressing symptoms or causing side effects. Available at http://medicines.necsu.nhs.uk/cumbria-shared-care-protocols/
ADHD drugs shared care guideline	An updated version of the shared care protocol for ADHD drugs is now available. This version now includes Lisdexamfetamine and contra-indications for each drug, whereas clinicians are directed to SPC or BNF for adverse effects and drug interactions. Available at http://medicines.necsu.nhs.uk/cumbria-shared-care-protocols/
Nefopam **RAG rating**	Nefopam 30mg tablets have been given a **BLACK** RAG rating for all indications for new patients following safety concerns. All current patients should be reviewed by their practice. Available at http://medicines.necsu.nhs.uk/cumbria-traffic-light-classification/
Ascorbic acid RAG rating	Ascorbic acid tablets have been given a **GREEN** RAG rating for scurvy and **BLACK** for all other indications. Available at http://medicines.necsu.nhs.uk/cumbria-traffic-light-classification/

Cumbria NICE Blood Glucose therapy algorithm - update	An updated version of the NICE Blood glucose lowering therapy in adults with type 2 diabetes treatment algorithm with Cumbria drug choices is now available. Available at http://medicines.necsu.nhs.uk/guidelines/cumbria-guidelines/
Ostomy care	This LMMG approved document is now available on the NECS MO website which Cumbrian Clinicians may wish to follow. Available at http://medicines.necsu.nhs.uk/guidelines/cumbria-guidelines/
NG56 Multimorbidity: clinical assessment and management	This guideline covers optimising care for adults with multi-morbidity (multiple long-term conditions) by reducing treatment burden (poly-pharmacy and multiple appointments) and unplanned care. It aims to improve quality of life by promoting shared decisions based on what is important to each person in terms of treatments, health priorities, lifestyle and goals. The guideline sets out which people are most likely to benefit from an approach to care that takes account of multi-morbidity, how they can be identified and what the care involves. This guideline includes recommendations on: • taking account of multi-morbidity in tailoring an approach to care • how to identify people who may benefit • how to assess frailty • principles of an approach to care that takes account of multi-morbidity • delivering the approach to care **1.1. Optimising care for adults with multimorbidity, by reducing treatment burden (polypharmacy and multiple appointments) and unplanned care:** **Steps to follow:** **1.1.1. Step 1** Discuss the purpose of an approach to care that takes account of multimorbidity. **1.1.2. Step 2** Establish disease and treatment burden. **1.1.3. Step 3** Establish patient goals, values and priorities

1.1.4. Step 4

Review medicines and other treatments taking into account evidence of likely benefits and harms for the individual patient and outcomes important to the person.

1.1.5. Step 5

Agree an individualised management plan.

Although adherence to this guideline needs to integrate all the above steps, specific recommendations relating to medicines optimisation (Step 4) are highlighted:

1.2. Reviewing medicines and other treatments

- When reviewing medicines and other treatments, use the database of treatment effects to find information on the effectiveness of treatments https://www.nice.org.uk/guidance/ng56/resources
- Consider using a screening tool (for example, the STOPP/START tool in older people) to identify medicine-related safety concerns and medicines the person might benefit from but is not currently taking.
- When optimising treatment, think about any medicines or non-pharmacological treatments that might be started as well as those that might be stopped.
- Ask the person if treatments intended to relieve symptoms are providing benefits or causing harms. If the person is unsure of benefit or is experiencing harms from a treatment discuss reducing or stopping the treatment
- Plan a review to monitor effects of any changes made and decide whether any further changes to treatments are needed (including restarting a treatment).
- Take into account the possibility of lower overall benefit of continuing treatments that aim to offer prognostic benefit, particularly in people with limited life expectancy or frailty.
- Discuss with people who have multimorbidity and limited life expectancy or frailty whether they wish to continue treatments recommended in guidance on single health conditions which may offer them limited overall benefit.
- Discuss any changes to treatments that aim to offer prognostic benefit with the person, taking into account their views on the likely benefits and harms from individual treatments and what is important to them in terms of personal goals, values and priorities.
- Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of further benefit from continuing bisphosphonate for another 3 years or of harms from stopping bisphosphonate after 3 years of treatment.
- Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.

A useful summary can be found here https://www.sps.nhs.uk/wp-content/uploads/2016/10/NICE-Bites-Sept-2016-No-90-Multimorbidity.pdf

Recommendations on New Medicines

	Drug	Licensed indication	Recommendation
The following drugs have been recommended as suitable for use	Hypertonic sodium chloride - 7% nebuliser solution Resp-Ease®	First choice for mobilise lower respiratory tract secretions in mucous consolidation. This product will replace Nebusal hypertonic saline 7% nebuliser solution.	AMBER

Lothian amendments

10.1 Drugs use in inflammatory arthritis	Ibuprofen is now first choice NSAID, diclofenac is second choice.

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News from the MHRA

Levonorgestrel containing emergency hormonal contraception: advice on interactions with hepatic enzyme unducers and contraceptive efficacy

(Drug safety update September 2016)

Medicines or herbal remedies that induce CYP3A4 enzyme reduce blood levels of levonorgestrel, which may reduce emergency contraceptive efficacy.

Updated advice for healthcare professionals:

- Women seeking emergency contraception who have used cytochrome P450 3A4 (CYP3A4) enzyme inducers within the last 4 weeks, should:

1. Preferably use a non-hormonal emergency contraception – ie, a copper intrauterine device.
2. If this is not an option, double the usual dose of levonorgestrel from 1.5 milligrams to 3 milligrams (ie, 2 packs)

- For these women:

1. Provide advice on highly effective ongoing contraception that is not affected by hepatic enzyme-inducing drugs (see guidance from the Faculty of Sexual Health and Reproductive Health)
2. Advise them to have a pregnancy test to exclude pregnancy after use of levonorgestrel containing emergency contraception
3. Advise them to seek prompt medical advice id they do become pregnant

This updated advice is in line with existing guidance from UK experts in sexual and reproductive health, and applies to both prescription and non-prescription supply which will help ensure that women receive consistent advice. Product information for healthcare professionals and women and outer packaging for levonorgestrel emergency contraception are being updated with this advice.

Posaconazole (Noxafil): tablets and oral suspension are not directly interchangeable

(Drug safety update September 2016)

Switching from posaconazole oral solution to tablets has resulted in cases of dose-related toxicity, whereas switching from tablets to oral solution has resulted in underdosing and lack of efficacy.

Advice for healthcare professionals:

- Posaconazole tablets and oral suspension are not directly interchangeable
- Switching from oral suspension to tablets can lead to overdosing and serious adverse drug reactions, whereas switching from tablets to oral suspension can lead to underdosing and lack of efficacy
- Prescribers should specify the dosage form for posaconazole on every prescription
- Pharmacists should ensure that the correct oral form is dispensed to the patients.

NICE guidance

These are brief summaries. The complete guidance should be consulted (www.nice.org.uk)

	Condition	Recommendations
NG53	Transition between inpatient mental health settings and community or care home settings	This guideline covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital. It aims to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it's planned and carried out. There are no specific prescribing recommendations
NG54	Mental health problems in people with learning disabilities: prevention, assessment and management	This guideline covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions, and help people with learning disabilities and their families and carers to be involved in their care.
NG55	Harmful sexual behaviour among children and young people	This guideline covers children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences. It aims to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence. It also aims to ensure no-one is unnecessarily referred to specialist services. 'Young people' refers mainly to those aged 10 to 18 but also includes people up to 25 with special educational needs or a disability. This guideline does not discuss people who have experienced sexual abuse. NICE will publish a guideline on child abuse and neglect in September 2017. There are no specific prescribing recommendations