NHS Cumbria Clinical Commissioning Group

PRESCRIPTION PAD

The Newsletter of the Cumbria Area Prescribing Committee

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Clinical Policy and Formulary News

Alternatives to strontium ranelate	As mentioned in the last Prescription Pad, the MHRA have issued further advice on restrictions on the use of strontium ranelate in the treatment of osteoporosis. The use of strontium ranelate in Cumbria is actually fairly small, about 30 prescriptions a month, which has been declining for the last couple of years anyway. These restrictions pertain to the use of strontium ranelate in patients with pre-existing cardiovascular disease. It is not necessary to stop strontium ranelate in patients who do not have cardiovascular disease. For **PRIMARY** prevention in women, the NICE-approved indications are identical for denosumab and strontium, so it is therefore reasonable to consider this as an alternative should this be required, providing NICE guidance was followed previously. If strontium is prescribed instead of bisphosphonate as a 'drug holiday' it is not appropriate to switch to denosumab – the patient should either be on bisphosphonate or have 'drug holiday'. For **SECONDARY** prevention in women, the NICE criteria for strontium and raloxifene are the same, so postmenopausal women may be switched over to raloxifene. The criteria for using denosumab are actually less stringent than that for both strontium and raloxifene, **AS LONG AS THE PATIENTS MEET THE NICE CRITERIA FOR TREATMENT.** It is important though that the NICE criteria are met before raloxifene or denosumab are prescribed. The alternatives for men are much more limited. Denosumab is only licensed for osteoporosis in men with prostate cancer (but it is not recommended for this indication by NICE) and raloxifene is not licensed for men at all. Consideration for teriparatide may be necessary by a specialist.
Hormone therapy for gender dysphoria	A recent circular from NHS England (SSC1417) states that 'GPs are encouraged to cooperate with Gender Identity Clinics (GICs) in the prescription and monitoring of drug treatments for gender dysphoria'. GPs are encouraged to provide the following components of the care pathway for people with atypical gender identity development: • the prescription of hormone therapy, as recommended for their patients by GIC gender specialist physicians • patient safety monitoring procedures, working in co-operation with GICs • provision of basic physical examinations (within the usual competences of GPs) and blood tests, as recommended by the GIC; • GIC will assist GPs by providing specific, relevant information and support for prescribing and monitoring, including the interpretation of blood test results.

<table>
<tr>
<td>LJF changes</td>
<td>Changes have been made to the section on the treatment of migraine. Many of these changes are in line with the NICE CG150 on the treatment of headache.

4.7.4.1 Acute attack
(a) Step 1
• The prescribing notes have been updated including emphasis that repeated doses of simple analgesia are not helpful in migraine. Patients not responding to 1- 2 single doses should move up to step 2.

(b) Step 2
• Choices box has been amended to rizatriptan as second choice. Almotriptan is included in prescribing notes as an alternative.

4.7.4.2 Migraine prophylaxis
• Second choice has changed from sodium valproate to topiramate. Formulations/dose and prescribing notes have been updated accordingly.
• Prescribing notes have been updated to include guidance for use of migraine prophylaxis in women of child bearing potential, slow titration of prophylactic medication and length of treatment.

4.7.4.3 Drug treatment of cluster headache
(a) acute attacks
• Second choice has changed from sumatriptan nasal spray to zolmitriptan nasal spray.</td>
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<td>Hyponatraemia</td>
<td>Following its implication in the death of a patient please note the following:

Hyponatraemia is defined as a serum sodium concentration of less than 135mmol/L. It occurs in up to 30% of hospitalised patients and can lead to a wide spectrum of clinical symptoms, from subtle to severe or even life threatening

Symptoms of hyponatraemia include:
<table>
<tr><td>Moderately severe</td><td>Nausea without vomiting
Confusion
Headache</td></tr>
<tr><td>Severe</td><td>Vomiting
Cardiorespiratory distress
Abnormal and deep somnolence
Seizures
Coma (Glasgow Coma Scale ≤8)</td></tr>
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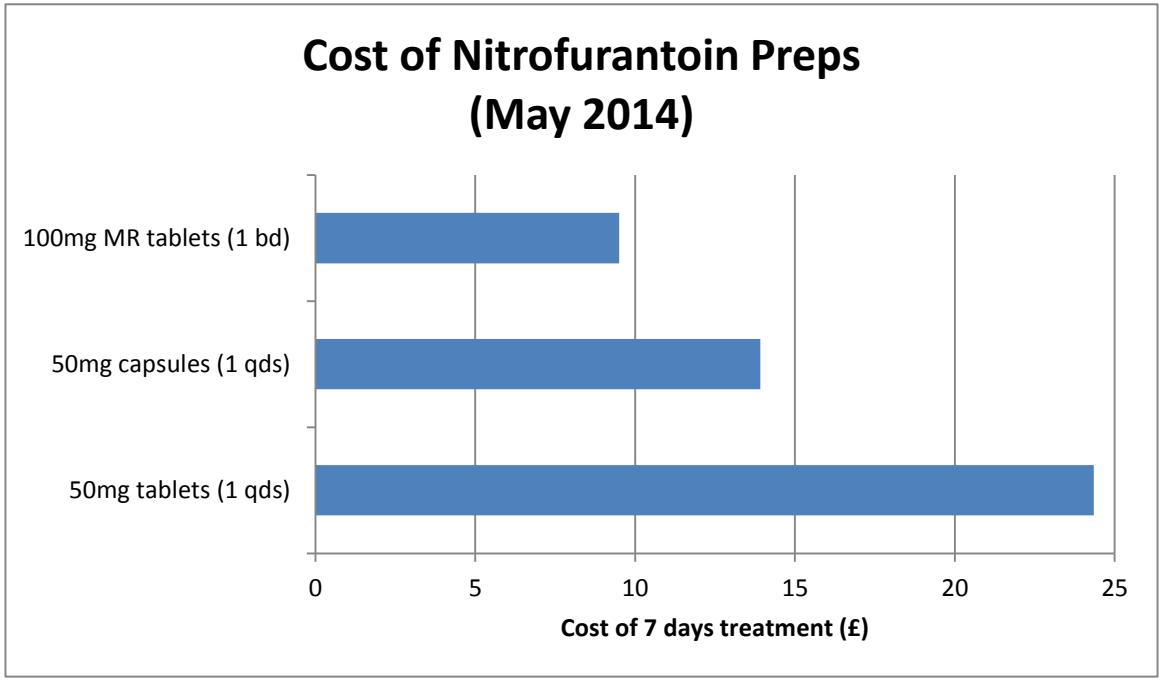
	Hyponatraemia can occur due to a number of causes, due to endocrine abnormalities, dilutional causes, or due to drugs. **The Map of Medicine (registration may be required) recommends that any patient with a serum sodium ≤115mmol/L should be referred immediately to hospital. If the serum sodium is 115-124mmol/L, seek advice from an endocrinologist regarding admission to hospital or urgent referral. If the serum sodium is greater than 125mmol/L, investigate for the cause of hyponatraemia.** The full European Guideline is available here. It includes a lot of information on causes and treatment.
Chondroitin and glucosamine prescribing	As mentioned later in the NICE guideline on osteoarthritis, the use of hyaluronans intra-articular injections and oral glucosamine are not recommended. There has been a significant decrease in the prescribing of both agents over the last few years, but prescribers are requested again to review the need for prescribing of these preparations.
Amoxicillin dose changes for children	The online BNF and BNFC now list higher doses of oral amoxicillin for children in line with Health Protection Agency (HPA) guidance. The paper BNF (67th edition, March 2014) does not list the new dose. The current recommended doses are: • Child 1 month to 1 year: 125mg three times daily, increased if necessary up to 30mg/kg three times daily. • Child 1-5 years: 250mg three times daily, increased if necessary up to 30mg/kg three times daily. • Child 5-12 years: 500mg three times daily, increased if necessary up to 30mg/kg (max 1g) three times daily. • Child 12-18 years: 500mg three times daily; in severe infection 1g three times daily. The standard dose of oral amoxicillin for adults was increased to 500mg three times daily (doubled in severe infection) in September 2013 and is reflected in the printed and online editions of the BNF (www.bnf.org)
Domperidone – restricted indications	The benefits and risks of domperidone have been reviewed by the MHRA. As domperidone is associated with a small increased risk of serious cardiac side-effects, the following restrictions to indication, dose and duration of treatment have been made, and new contra-indications added: • domperidone should only be used for the relief of the symptoms of nausea and vomiting • domperidone should be used at the lowest effective dose for the shortest possible duration (max. treatment duration should not normally exceed 1 week) • domperidone is contra-indicated for use in conditions where cardiac conduction is, or could be impaired, or where there is underlying cardiac disease, when administered concomitantly with drugs that prolong the QT interval or potent CYP3A4 inhibitors, and in severe hepatic impairment • the recommended dose in adults and adolescents over 12 years and over 35 kilograms is 10mg up to 3 times daily • the recommended dose in children under 35 kilograms is 250 micrograms/kg up to 3 times daily • oral liquid formulations should be given via an appropriately designed, graduated oral syringe to ensure dose accuracy.

Discontinuation of nitrofurantoin capsules 50mg	The manufacturers of 50mg nitrofurantoin capsules (Macrodantin®) have announced that they are ceasing manufacturer. A generic capsule will be available, but will be four times the price of the present preparation. If clinicians wish to prescribe nitrofurantoin for an uncomplicated UTI, the least expensive option is the 100mg modified-release preparation. This is given twice a day



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Recommendations on New Medicines

The following drugs were <u>not approved</u> by SMC and LJF, on the basis that a cost-effectiveness case was not submitted by the manufacturer:	Lomitapide capsules (Lojuxta®)	Adjunct to a low-fat diet and other lipid-lowering medicinal products with or without low density lipoprotein (LDL) apheresis in adult patients with homozygous familial hypercholesterolaemia.	Not recommended **BLACK**
	Saxagliptin tablets (Onglyza®)	Monotherapy in adult patients aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to contra-indications or intolerance.	Not recommended **BLACK**
The following drugs were <u>not approved</u> by SMC and LJF, on the basis that a cost-effectiveness case was not proven by the manufacturer:	Alogliptin tablets (Vipidia®)	For adults aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control in combination with other glucose lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control.	Not recommended **BLACK**
	Colestilan sachets (BindRen®)	Treatment of hyperphosphataemia in adult patients with chronic kidney disease (CKD) stage 5 receiving haemodialysis or peritoneal dialysis.	Not recommended **BLACK**
	Insulin degludec injection (Tresiba®)	Treatment of diabetes mellitus in adults.	Not recommended **BLACK**
The following drugs were <u>not approved</u> by LJF, on the basis that other agents were preferred by the LJF:	Solifenacin and tamsulosin tablets (Vesomni®)	Treatment of moderate to severe storage symptoms (urgency, increased micturition frequency) and voiding symptoms associated with benign prostatic hyperplasia in men who are not adequately responding to treatment with monotherapy.	Not recommended **BLACK**

News from the MHRA

Combined oral contraceptives

A review of the latest evidence on the risk of thromboembolism in association with combined hormonal contraceptives (CHCs) has concluded that:

- the risk of blood clots with all low-dose CHCs is small
- there is good evidence that the risk of venous thromboembolism (VTE) may vary between products, depending on the progestogen
- CHCs that contain levonorgestrel, norethisterone, or norgestimate have the lowest risk of VTE (estimated 5 to 7 VTE's per 10,000 women per year of use); the risk with gestodene, desogestrel, drospirenone, etonogestrel and norelgestromin is higher (about 9 to 12 VTE's per 10,000 women per year of use)
- the benefits of any CHC far outweigh the risk of serious side effects
- prescribers and women should be aware of the major risk

Advice for healthcare professionals:

- there is no need for any woman to change her CHC on the basis of this review and the updated information
- consider using the prescribing checklist to help CHC consultations
- carefully consider: any contraindications for use; the difference in risk of VTE between products; and a woman's current risk factors when prescribing a CHC
- reassess a woman's risk factors at routine appointments
- discuss the risk of VTE with each woman, and raise awareness of the signs and symptoms of thromboembolism when prescribing a CHC; consider providing her with the further information mentioned above
- always consider the possibility of a CHC-associated thromboembolism when presented with a woman who has relevant symptoms
- ask all women with signs and symptoms of thromboembolism if they are taking any medicines or if they are using a combined hormonal contraceptive

The MHRA has a checklist which may help in decision making during consultations.

LJF choices are:

First Choice: Rigevidon® (contains levonorgestrel 150 micrograms)

Second Choice: Millinette® 30/75 (contains gestodene 75 micrograms) or Gedarel® 30/150 (contains desogestrel 150 micrograms)

Approximately three-quarters of COC prescribing in Cumbria are for 'lowest risk' progestogens.

Orlistat: theoretical interaction with antiretroviral HIV medicines	Orlistat may theoretically reduce the absorption of antiretroviral HIV medicines. Initiate orlistat treatment only after careful consideration of the possible impact on efficacy of antiretroviral HIV medicines. People who take antiretroviral HIV medicines should consult their doctor before taking non-prescription 60mg orlistat. • initiate orlistat treatment only after careful consideration of the possible impact on efficacy of antiretroviral HIV medicines • pharmacists should advise people who take antiretroviral HIV medicines to consult their doctor before taking orlistat in light of the possible interaction • suspected adverse reactions with orlistat, whether prescribed or obtained over the counter, should be reported on a Yellow Card (http://www.mhra.gov.uk/yellowcard)
St John's Wort: interaction with hormonal contraceptives, including implants – reduced contraceptive effect	St John's wort interacts with hormonal contraceptives. This interaction reduces the effectiveness of these contraceptives and increases the risk of unplanned pregnancy. This applies to all hormonal contraceptives except intrauterine devices, for which there are currently no data. St John's wort is occasionally purchased over the counter for the self-treatment of depression. Prescribers may not be aware that patients are taking this preparation. • advise women taking hormonal contraceptives for pregnancy prevention not to take herbal products containing St John's wort • encourage women to read the Patient Information Leaflet that comes with their hormonal contraceptive

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NICE guidance

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

	Drug	Condition	Resume
TA305	Aflibercept	Macular oedema (central retinal vein occlusion)	Recommended as an option for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion. RED
TA306	Pixantrone	Lymphoma, non-Hodgkin's, relapsed, refractory	Recommended as a possible treatment for adults with multiply relapsed or refractory aggressive non-Hodgkin's B-cell lymphoma if: • they have previously been treated with rituximab and • they are having third- or fourth-line treatment RED
TA307	Aflibercept	Colorectal cancer (metastatic)	Not recommended for metastatic colorectal cancer that has got worse after taking chemotherapy that includes oxaliplatin. BLACK
TA308	Rituximab (with corticosteroids)	Vasculitis (anti-neutrophil cytoplasmic antibody-associated)	Recommended as a possible treatment for people with anti-neutrophil cytoplasmic antibody-associated vasculitis (that is, severely active granulomatosis with polyangiitis [also known as Wegener's granulomatosis] and microscopic polyangiitis) if: • more treatment with cyclophosphamide would exceed the maximum amount of cyclophosphamide they can have or • cyclophosphamide is not suitable for them or they cannot take it or • they want to have children and treatment with cyclophosphamide may affect their fertility or • the disease has stayed active or got worse after a course of cyclophosphamide lasting 3–6 months or • the person has had cancer affecting the lining of the bladder and other parts of the urinary system. RED

CG177	Osteoarthritis	The current update addresses issues around decision-making and referral thresholds for surgery (base decisions on referral thresholds on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation), and includes new recommendations about diagnosis and follow-up. It recommends that glucosamine, chondroitin, hyaluronans and acupuncture should **not** be offered. The advice on drugs has not been changed since the 2008 revision, pending a review by the MHRA on OTC analgesics. However, the GDG notes the findings of the evidence review on the effectiveness of paracetamol that was presented in the consultation version of the guideline. That review identified reduced effectiveness of paracetamol in the management of osteoarthritis compared with what was previously thought. The GDG believes that this information should be taken into account in routine prescribing practice until the planned full review of evidence on the pharmacological management of osteoarthritis is published.
CG178	Psychosis and schizophrenia in adults	Much of the guidance relates to referral policies and management by mental health specialists. Relevant guidance on the use of medicines in primary care include: **Treatment and management** **Initial episode** Do **NOT** start antipsychotic medication in primary care unless in consultation with a consultant psychiatrist. **Subsequent acute episodes** Offer crisis resolution and home treatment teams if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention services or other community teams to effectively manage it. If a person needs hospital care, consider the impact on them, their carers and family members. Ensure the setting is suitable for the person's age, gender and level of vulnerability. Offer: • oral antipsychotic medication, **AND** • psychological interventions; family intervention and individual CBT

		Choice of drug should be influenced by the same criteria recommended for starting treatment. Take into account the clinical response and side effects associated with current and previous medication. **Antipsychotic medication** The choice of antipsychotic medication should be decided between the person and healthcare professional, taking into account the views of the carer if the patient agrees. **Monitoring of antipsychotics** Monitoring should be the responsibility of the secondary care team for at least the first 12 months or until the person's condition has stabilised. It can then be transferred to primary care as a shared care agreement. Monitor and record the following regularly throughout treatment, but especially during titration: • response to treatment, including changes in symptoms and behaviour, • side effects of treatment, • the emergence of movement disorders, • weight; weekly for 6 weeks, at 12 weeks, at 12 months then annually (plotted on a chart), • waist circumference; annually (plotted on a chart), • pulse and blood pressure; at 12 weeks, at 12 months then annually, • fasting blood glucose, HbA1c, and blood lipid levels at 12 weeks, at 1 year and then annually, • adherence and physical health.

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