NHS
Milton Keynes Clinical Commissioning Group

# PRESCRIBING NEWS

January 2018

## CCG Prescribing Group 1st November 2017

- Welcome to Zainab Al-Shalchi our new North Neighbourhood Pharmacist.
- Guidelines for recurrent UTI were approved – these can be found on the MK Formulary website.
- Changes to monitoring of blood glucose and choice of meters and strips were discussed. Practices are asked to use the most cost effective strips (under £10 per box)
- Targets for the 2018-19 Prescribing Incentive scheme were considered.

## Milton Keynes Prescribing Advisory Group (MKPAG) 24th November 2017

**The key points discussed were:**

- MKPAG asked for further information on Freestyle Libre. Prescribing is on hold until the next meeting in January. Please look out for further guidance.
- The shared care guidelines for DMARDs are being updated in conjunction with the new rheumatologists at MK hospital.
- Guanfacine for ADHD was left on the fomulary as it had been used in one patient. However GPs should decline any request to prescribe it as it should be prescribed in secondary care only.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website:
http://www.formularymk.nhs.uk/Minutes/

## Revised Antimicrobial Prescribing Guidance

The local antibiotic prescribing guidance has been updated in line with the recent Public Health England Guidance. These updates from PHE seem more frequent now so please make sure that you work from the latest versions. The guidance can be viewed on the formulary website and has been added to SystmOne. The link to the document on the PHE website is:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664742/Summary_tables_infections_in_primary_care.pdf

The main changes are:-

| | |
|---|---|
| New sections on Scarlet Fever and Mastitis | Sinusitis – Pen V now first line |
| AOM – clarithromycin added as extra choice | Acute bronchitis – Pen V removed as an option |
| Recurrent UTI – Pivmecillinam no longer included | PID – Ofloxacin substituted for doxycycline |

## Unprecedented Medicines Shortages

You will probably be aware that there have been severe shortages of some generic medicines in recent months, and in early December 2017, The Times featured an article on its front page raising concerns about patients not being able to get hold of vital medicines due to drug shortages. Community pharmacy teams are being put in a very difficult situation at the moment and most have to work far harder than usual to obtain supplies of certain medicines for their patients.

**Why are there so many drug shortages at the moment?**

We have seen an increase in supply issues with generic medicines since late spring/early summer 2017. This was in part due to the closure of two generics manufacturing plants, but may also be a consequence of the UK being a less attractive market for manufacturers. Generics prices in England are incredibly low compared to most parts of the world, because DH's policy to incentivise community pharmacies to reduce medicines prices for the NHS has worked incredibly well. There is a global market for generics, so international manufacturers can choose to sell where they will make the best financial return.

**What's being done about it?**

PSNC, the national community pharmacy negotiating body, have been pressing DH and the Pharmacy Minister for urgent intervention to ensure the resilience of the supply chain and the provision of services to patients. However, in the short-term, pharmacies must each month await the granting of so-called 'price concessions' which recognise where medicines are not available to purchase at Drug Tariff prices, and help pharmacies to pay the inflated drug prices. This is having a significant impact on the CCG prescribing budget.

**What can GPs and other prescribers do to help the situation?**

We ask that prescribers are willing to consider alternatives when pharmacies are unable to obtain stock at the Drug Tariff price. Pharmacists may call GPs to discuss possible alternative products and request new prescriptions for affected patients. Writing a prescription for an alternative medicine may be the quickest way for the patient to receive treatment. If in doubt, please speak to your neighbourhood pharmacist.

## Outcome of national consultation on stopping prescribing 18 low value medicines

The Next Steps document, published on 31 March 2017, included as part of the NHS 10 Point Efficiency Plan a commitment to review the appropriateness of aspects of NHS-prescribing, including products deemed to be of 'low clinical value' and/or available to the public over the counter (OTC). In July 2017, the NHS England Board approved consultation on a set of proposals to limit the prescription of 18 products costing a total of £141million per year, which it was felt should not be routinely prescribed in primary care. NHS England and NHS Clinical Commissioners consulted publicly on these proposals between July and October 2017.

Work focused on developing guidelines for an initial list of eighteen products which fall into one or more of the following categories:

- Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns;
- Products which are clinically effective but where more cost-effective products are available, including some products that have been subject to excessive price inflation; and
- Products which are clinically effective but due to the nature of the product are deemed a low priority for NHS funding.

The outcome from the consultation may be found at:
https://www.england.nhs.uk/wp-content/uploads/2017/11/05-pb-30-11-2017-items-which-should-not-be-routinely-prescribed-in-primary-care.pdf

The medicines included are:-

| | | |
|---|---|---|
| Liothyronine | Dosulepin | Immediate release fentanyl |
| Co-Proxamol | Tadalafil once daily | Oxycodone + naloxone combination |
| Travel Vaccines | Prolonged release doxazosin | Perindopril arginine |
| Lidocaine Plasters | Paracetamol + Tramadol combination | Trimipramine |
| Rubefacients (excluding topical NSAIDS) | Omega-3 Fatty Acid Compounds | Lutein and Antioxidants |
| Glucosamine and Chondroitin | Herbal Treatments | Homeopathy |

Local actions include:

- Milton Keynes Prescribing Advisory Group to incorporate the recommendations into the formulary
- MKCCG to add warning messages to OptimiseRx to prompt prescribers not to prescribe for new patients and to review / deprescribe where the patient is already receiving a treatment. This may require a referral or discussion with specialists
- MK Hospital and CNWL to ensure prescribers are informed of these changes.
- GPs to refer requests for prescribing back to the specialist. It is very important that this is done.
- Patient information leaflets will be available on S1 soon to support these changes.

The consultation also sought views on potentially limiting the prescribing of medicines that are available over the counter. This consultation has gone live. Further details are available at:
https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed/

Both these national consultations support the work already being done by practices in Milton Keynes to limit prescribing in these areas as many are part of the Prescribing Incentive Scheme CEP target.

## High Value medicines, high value outcomes?

The Direct Oral Anticoagulants (DOACs- otherwise known as NOACs) spend in MKCCG has now exceeded £1m per year and is rising more rapidly than any other group of medicines. The national spend is £320m per year. Is this providing good value for money?

Stroke prevention in AF is a high priority for the NHS. NICE CG 180 sets out the criteria for offering and considering anticoagulation. However NICE does not prioritise the use of any DOAC or warfarin.

The Sentinel Stroke National Audit Programme shows that the % patients with known AF before their stroke taking anticoagulants has gone up as % taking antiplatelets has fallen but the number taking neither has remained steady. Within the anticoagulation group, the % taking DOACs varies from 16% to 75% across the country (MK currently around 50%). However, the annual number of AF related strokes has only fallen nationally by 300 between 2015/16 and 2016/17. This represents 0.4% of the total 74,000 strokes annually.

Almost 20% of patients who were prescribed an anticoagulant at discharge were no longer taking them at 6 months. It is important to check compliance with the DOACs as they can easily become "just another medicine" that patients choose not to take. At least with warfarin you get some certainty of compliance.

## Tamoxifen and SSRIs or SNRIs – is there a potential interaction?

The selective oestrogen receptor modulator tamoxifen has been used to treat hormone receptor positive breast cancer in the adjuvant setting for over three decades, where it has been shown to reduce annual breast cancer mortality rate by a third and five-year recurrence by a half. Depression and anxiety are common co-morbidities with breast cancer. Estimates suggest 20-30% of patients taking tamoxifen are co-prescribed anti-depressants either for psychiatric reasons or off-label for tamoxifen-induced vasomotor symptoms.

Tamoxifen is a prodrug that is extensively metabolised to more potent active metabolites by cytochrome P450 isoenzymes (CYP450) and CYP2D6 in the liver. Inhibition of these enzymes by certain antidepressants potentially prevents formation of the active compounds, therefore negating clinical effect. CYP450 iso-enzymes are highly subject to genetic polymorphism, and an individual's capacity to metabolise tamoxifen varies according to their CYP2D6 genotype.

Different SSRIs and SNRIs inhibit CYP2D6 to varying degrees. Of the SSRIs, paroxetine is a potent inhibitor and fluoxetine a moderate-to-potent inhibitor of CYP2D6. Citalopram, escitalopram, sertraline and fluvoxamine are weak inhibitors of CYP2D6. With regard to SNRIs, duloxetine is a moderate inhibitor whereas venlafaxine is a weak inhibitor.

There is some evidence for a clinically relevant interaction between tamoxifen and SSRIs/SNRIs. MHRA, NICE and the manufacturer of tamoxifen all recommend that the potent CYP2D6 inhibitors fluoxetine and paroxetine should not be co-prescribed with tamoxifen. Weak inhibitors such as sertraline, escitalopram, citalopram or venlafaxine are more suitable for prescribing in this patient population. Patients currently taking tamoxifen with an antidepressant considered a potent or moderate CYP2D6 inhibitor (paroxetine, fluoxetine, duloxetine) may wish to switch to an antidepressant that is a weak CYP2D6 inhibitor (citalopram, escitalopram, sertraline). Please contact your neighbourhood pharmacist if you require advice on switching antidepressants.

## Medicines recommended by the hospital

Practices have started sending prescribing queries straight back to the hospital using the pro-forma that can be found on SystmOne in the Comms and Letters section (thank you!). However, not everyone is aware that these forms can be emailed directly from SystmOne.

Once the form is filled in then you have three options.

- You can print the form, scan it and attach that to an email to send to the address on the form
- Once the letter is saved/closed then if you right click on the letter, one of the options is to export it so you can save it on the computer as a Word or PDF doc, and then attach it to an email (saves the need for scanning)
- If you have Outlook open at the same time, you can email directly from S1 – when the letter is open, select 'File' and then 'Save & Send' as per the screen shot below. This will open a new email with the template attached in whichever format you selected.

Whichever option you choose, please ensure you are sending the email from an nhs.net account and remember to also attach a copy of the original request from the specialist. You can also copy in either your neighbourhood pharmacist or mkccgpharmacy@nhs.net

## Prescribing special products

If a surgery gets information from a hospital as to where a specials product can be obtained please can you try to send the information with the prescription for the community pharmacy to help prevent even more expensive items being supplied. There have been recent examples of high cost specials being purchased when Guys Hospital are able to supply at low cost.

## Prescribing Incentive Scheme – Polypharmacy and deprescribing reviews

It has been interesting looking at the reviews submitted by practices as the first part of the polypharmacy and deprescribing work within the Prescribing Incentive Scheme.

Two concepts have provided some challenges to some prescribers:

- Numbers Needed to Treat (NNT) – how many people have to be treated for how long for one to avoid an event (and therefore what is the balance between risks and benefits and anticipated life expectancy) - and
- Anticholinergic Burden – am I increasing the risk of cognitive dysfunction and delirium by prescribing several medicines each with anticholinergic side effects?

Medicine interventions on the Pincer list were not consistently recognised. These cover three clinically important errors:

1. Patients with a history of peptic ulcer prescribed non-selective non-steroidal anti-inflammatory drugs (NSAIDs) without co-prescription of a proton-pump inhibitor
2. Patients with a history of asthma prescribed β blockers;
3. Patients > 75 years old prescribed angiotensin converting enzyme (ACE) inhibitors or loop diuretics without assessment of urea and electrolytes in the preceding 15 months.

Medicines most likely to lead to hospital admissions include:

| | |
|---|---|
| Oral corticosteroids | Hypoglycaemics (insulin or gliclazide) |
| NSAIDs | Antihypertensives |
| Opioid Analgesics | Aspirin and other antiplatelets |
| Laxatives | Digoxin |
| Hypnotics | Antiarrhythmics |
| Antipsychotics | Anticoagulants inc DOACs |
| PPIs | |

These issues will be discussed at the Prescribing Workshop on January 25th. All practices must send at least 1 GP to qualify for the incentive scheme. If you haven't already booked your place, please use this link to do so https://www.surveymonkey.co.uk/r/PLTJanuary2018

## In brief ……..

1. Patients taking warfarin should be advised not use over-the-counter miconazole oral gel (Daktarin). If you plan to prescribe miconazole oral gel in a patient on warfarin, you should closely monitor them and advise that if they experience any sign of bleeding, they should stop miconazole oral gel and seek immediate medical attention. Miconazole inhibits several P450 isozymes, including CYP2C9, which can heighten the anticoagulant effect of warfarin and lead to an increase in INR values (and subsequent bleeding complications).

2. There have been reports of cardiac events including QT prolongation, torsades de pointes, and cardiac arrest in patients who have taken high or very high doses of loperamide as a drug of abuse or for self-treatment of opioid withdrawal.

3. Gabapentin has been associated with a rare risk of severe respiratory depression even without concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment, concomitant use of central nervous system (CNS) depressants, and elderly people might be at higher risk of experiencing severe respiratory depression. Dose adjustments might be necessary in these patients.

4. Cases of sexual dysfunction, predominantly involving erectile dysfunction and decreased libido, have been reported rarely in patients taking oral isotretinoin for severe acne.

5. The risk of bleeding in patients taking DOACs is increased if they are also on aspirin, clopidogrel, NSAIDs, SSRIs or SNRIs.

6. The MHRA has reminded prescribers that Quinine has dose-dependent QT-interval-prolonging effects and should be used with caution in patients with risk factors for QT prolongation or in those with atrioventricular block.

**The Pharmaceutical Advisers can be contacted on 01908 278744 or 278713 or speak to your neighbourhood pharmacist**