LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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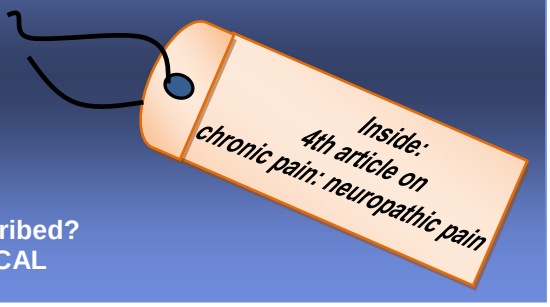
NHS Lothian

In this issue …



Hepatitis C - patients and their medicines

Hepatitis C virus (HCV) is a blood borne virus and has been recognised as a major public health concern. Chronic HCV has a prevalence of around 0.8% in the adult population. It is a slowly progressive disease. Around 10% of patients will develop liver cirrhosis over 15 to 20 years, leading to increased morbidity and mortality, with associated implications such as liver transplantation.

The goal of HCV treatment is to obtain a sustained viral response, which is an undetectable viral load six months after the cessation of therapy. This represents a cure. Until 2011, standard of care treatment consisted of dual therapy of pegylated interferon and ribavirin for 24 to 48 weeks dependent on genotype. Since then, the first and subsequent generations of direct acting antivirals (DAAs) have been introduced.

Treatment is rapidly evolving. Since January 2014 there have been five new DAAs launched onto the market. These medicines significantly improve cure rates (up to 95% in clinical trials) and have shorter duration of therapy (8 to 24 weeks) with a more tolerable side-effect profile. DAAs may be used in combination with ribavirin and/or pegylated interferon, or with each other, allowing for interferon-free regimens. This is beneficial for patients who are either unable to tolerate interferon or have a previous non-response to treatment. Despite the high cost of these new medicines and the large number of patients they are considered to be cost-effective.

The DAAs currently available are:
boceprevir, daclatasvir, dasabuvir, simeprevir, sofosbuvir, telaprevir, ledipasvir/sofosbuvir, and ombitasvir/paritaprevir/ritonavir.

DAAs have potential for interactions due to their varying effect on cytochrome P450 isoenzymes and P-glycoprotein. During assessment, patients will be asked about all of their medicines to screen for any potential interactions. Any new medicines commenced during HCV treatment should be checked for interactions. The University of Liverpool www.hep-druginteractions.org website has up-to-date information.

Thanks to Katherine Davidson, Senior Clinical Pharmacist, for contributing this article.

Hepatitis C services

These are delivered from the Regional Infectious Diseases Unit, WGH and Hepatology Services, RIE. All patients with hepatitis C are considered for treatment, regardless of genotype, disease severity and treatment history. Treatment with DAAs is prioritised for patients depending on clinical need such as advanced liver disease or other circumstances such as severe psychiatric contraindication to interferon.

New service for medicines

A service has been introduced where DAAs are prescribed by the specialist services and dispensed by community pharmacists. Other hepatitis C medicines are dispensed in one of the hospital pharmacies at present but may move to community pharmacy.

Care initiated and delivered by specialist service, including providing prescriptions.

↓

Patients choose a community pharmacy (CP).

↓

Specialist service contacts CP to agree start date and provide treatment information.

↓

Specialist service posts prescription direct to CP; medicine is dispensed and patients collect from CP.

↓

Patient continues to attend specialist service at regular intervals and attends CP for their medicines.

↓

The community pharmacist is encouraged to liaise with the specialist service regarding any issues such as adherence or queries from the patients.

↓

Support for CPs is available at www.communitypharmacy.scot.nhs.uk/nhs_boards/NHS_Lothian/lothian_index.html

Any queries should be directed to the specialist service and not referred to GPs.

Helping patients manage neuropathic pain

The prevalence of neuropathic pain is not clear. Older estimates have suggested it to be about 1-2% but the prevalence based on newer questionnaire based studies suggest it to be much higher (6-8%).[1] The costs are not known but back pain alone was estimated to cost £12 billion per annum in the UK in 1998[2] with an estimated 4.9 million days to employee absenteeism through work-related back pain.[3]

Neuropathic pain is a symptom that develops as a result of damage to, or dysfunction of, the nervous system. Causes include diabetic neuropathy, trigeminal neuralgia, post-herpetic neuralgia, radicular pain, pain after surgery, chemotherapy-induced neuropathy, injury to nerves, stroke, spinal cord injury and multiple sclerosis. Neuropathic pain should be suspected in all patients who have persistent pain despite the fact that healing has apparently taken place. Patients often find it hard to describe their symptoms. Symptoms may be constant or intermittent, and can be spontaneous or provoked in nature. The pain is typically described as shooting, stabbing, burning, tingling or itching. Patients will also have abnormal sensory signs, the two most common being **allodynia** — pain caused by a stimulus that does not normally provoke pain (e.g. light touch from clothing) and **hyperalgesia** — an increased response to a stimulus that is normally painful.[4]

The diagnosis is often a clinical diagnosis but there are a number of validated scales such at the LANSS pain scale, the DN4 or painDETECT[5] (the list is not exhaustive). These may prove useful.

Consider non-pharmacological and supported self management for all patients. For more information see Chronic Pain Scotland website which is for patients and healthcare professionals.

SIGN 136 includes a neuropathic pain pathway from diagnosis through to specialist referral.[6]

LJF section 4.7.3 recommendations

1st choice

amitriptyline initially 10mg at night increased gradually, by 10mg per week to 25-125mg daily
or
gabapentin 300mg at night, dose increased by 300mg per week, usually a minimum dose of 1.2g per day (in 3 divided doses) (max 3.6g daily)[2]

In the older patient, amitriptyline is particularly likely to cause postural hypotension, urinary retention and constipation.

Consider using amitriptyline and gabapentin in combination if pain is severe and not responding to a single agent.

This is the fourth and last of a series of articles on chronic pain.

Other medicines

- Pregabalin may be prescribed if first and second line treatments have failed or the patient is unable to tolerate them. Discontinue if there is no therapeutic benefit after an eight week trial.
- Carbamazepine is first choice for trigeminal neuralgia.
- Duloxetine may be used for diabetic peripheral neuropathic pain as second or third line therapy.
- Lidocaine 5% medicated plaster may be used topically for the treatment of post-herpetic neuralgia, in those patients who are intolerant of first-line systemic therapies or where these therapies have been ineffective.
- Opioids should only be used in carefully selected patients. Only long-acting preparations should be used.
- Tricyclic antidepressants (TCAs) should not be used for the management of pain in patients with chronic low back pain.[2]
- Some patients find amitriptyline excessively sedating. Alternative agents such as nortriptyline or imipramine may be used.[2] (Typical doses for both are 25-75mg at night.)
- Patients should be warned of likely side effects and that, unlike conventional analgesics, TCAs and antiepileptics may have to be taken regularly for four to six weeks at therapeutic dose before the full analgesic effect is appreciated.

References

1. Smith BH, Torrance N. Epidemiology of neuropathic pain. *Pain Manag* 2011;*1*:87-96.
2. Management of chronic pain. Clinical Guideline 136. Scottish Intercollegiate Guidelines Network. December 2013. www.sign.ac.uk
3. Media Resources. The British Pain Society. www.britishpainsociety.org/media-resources/
4. Neuropathic pain – drug treatment. Clinical Knowledge Summaries. The National Institute for Health and Care Excellence. Revised April 2015. http://cks.nice.org.uk/neuropathic-pain-drug-treatment#!backgroundsub [Accessed 11.06.15]
5. Cruccu G *et al.* EFNS guidelines on neuropathic pain assessment. *Eur J Neurol* 2010;*17(8):*1010-8. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-1331.2010.02969.x/abstract;jsessionid=74BA070A7CEC9D36D383DC56FBDB3468.f01t02 [Accessed 11.06.15]
6. Pathway for patients with neuropathic pain. Clinical Guideline 136. Scottish Intercollegiate Guidelines Network. December 2013. www.ckp.scot.nhs.uk/Published/PathwayViewer.aspx?id=610 [Accessed 11.06.15]

Systemic Anti-Cancer Therapy (SACT) – do not prescribe in primary care

Systemic anti-cancer therapy (SACT) includes all biological and cytotoxic chemotherapy prescribed for any malignant indication.

How is it managed?

SACT must be managed (prescribed, verified, dispensed) in hospital in accordance with national[1] and local[2] guidance. All cancer networks are required to have processes for training staff and to manage the complexity, potential adverse effects and specific monitoring requirements of SACT.

SACT that is commenced during hospital admission will be included on TRAK Immediate Discharge Letters (IDLs) to ensure there is a complete record of the patient's medicines. This is for information only; no SACT should be subsequently prescribed or dispensed in primary care. Any SACT that has been prescribed in hospital will continue to be dispensed and supplied from hospital.

Why is this important?

GPs should not prescribe these drugs, nor should community pharmacists dispense them.

What controls are in place?

Preventive controls in place rely on raising awareness of the guidance amongst GPs and community pharmacists. There is no limitation on what a community pharmacy can order (with the exception of some drugs such as thalidomide), and there is no facility currently in the prescribing system to block the prescribing of SACT. The control relies on GPs and community pharmacists knowing that these drugs should not be prescribed in primary care.

Please note that cytotoxic drugs used in non-malignant conditions (e.g. methotrexate), which may be prescribed in primary care via shared care arrangements are not governed by these guidelines.

Key messages

- **SACT should not be prescribed in primary care or supplied by community pharmacies**
- **Any SACT commenced during a hospital admission will continue to be dispensed and supplied from hospital.**

References

1. Revised guidance for the safe delivery of systemic anti-cancer therapy. CEL 30 (2012). The Scottish Government. July 2012. www.sehd.scot.nhs.uk/mels/CEL2012_30.pdf
2. Guidelines for the Safe Use of Systemic Anticancer Therapy. NHS Lothian. July 2014. http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/Haematology/policy/Documents/Guidelines%20for%20the%20safe%20use%20of%20systemic%20anti-cancer%20therapies.pdf

Thanks to Amanda McLean, Specialist QA Pharmacist, and Aili Cameron, Specialist Cancer Care Pharmacist, for contributing this article.

Triptans and SSRI/SNRI: can they be co-prescribed?

Serotonin syndrome is a relatively uncommon, but potentially life-threatening, adverse drug reaction caused by excessive serotonergic activity. Both triptans (serotonin agonists) and selective serotonin/noradrenaline re-uptake inhibitors (SSRIs/SNRIs) have serotonergic activity; therefore co-administration might have additive effects and increase the risk of serotonin syndrome. As migraine and depression often occur together, there is significant potential to co-prescribe these agents.

Current advice is to monitor for signs and symptoms of serotonin syndrome (e.g. restlessness, sweating, tremor, shivering) particularly when treatment is started, when doses are increased, or when another serotonergic medicine is added to the patient's regimen.

In theory, triptans with lower lipid solubility and a short half-life may be preferred (e.g. sumatriptan, rizatriptan, see LJF section 4.7.4 Antimigraine drugs.

When triptans were first launched, co-prescription with SSRIs was contraindicated. Subsequent clinical experience resulted in the contraindication being downgraded to a caution. Currently, all UK Summaries of Product Characteristics (SPCs) for triptans and SSRIs/SNRIs warn of a possible interaction. The SPC for citalopram recommends against concurrent use.

Key message

- **Clinical experience indicates that combined use is normally uneventful, and if required, a triptan and SSRI/SNRI can be co-prescribed.**

References

1. Triptans and SSRI or SNRI antidepressants - is there an interaction? Q&A 48.7. UK Medicines Information. November 2013. www.medicinesresources.nhs.uk/GetDocument.aspx?pageId=504048 [Accessed 11.06.15]
2. Stockley's Drug Interactions. www.medicinescomplete.com
3. Summaries of Product Characteristics. www.medicines.org.uk

Learn the quick step - updates for eLJF-CLINICAL

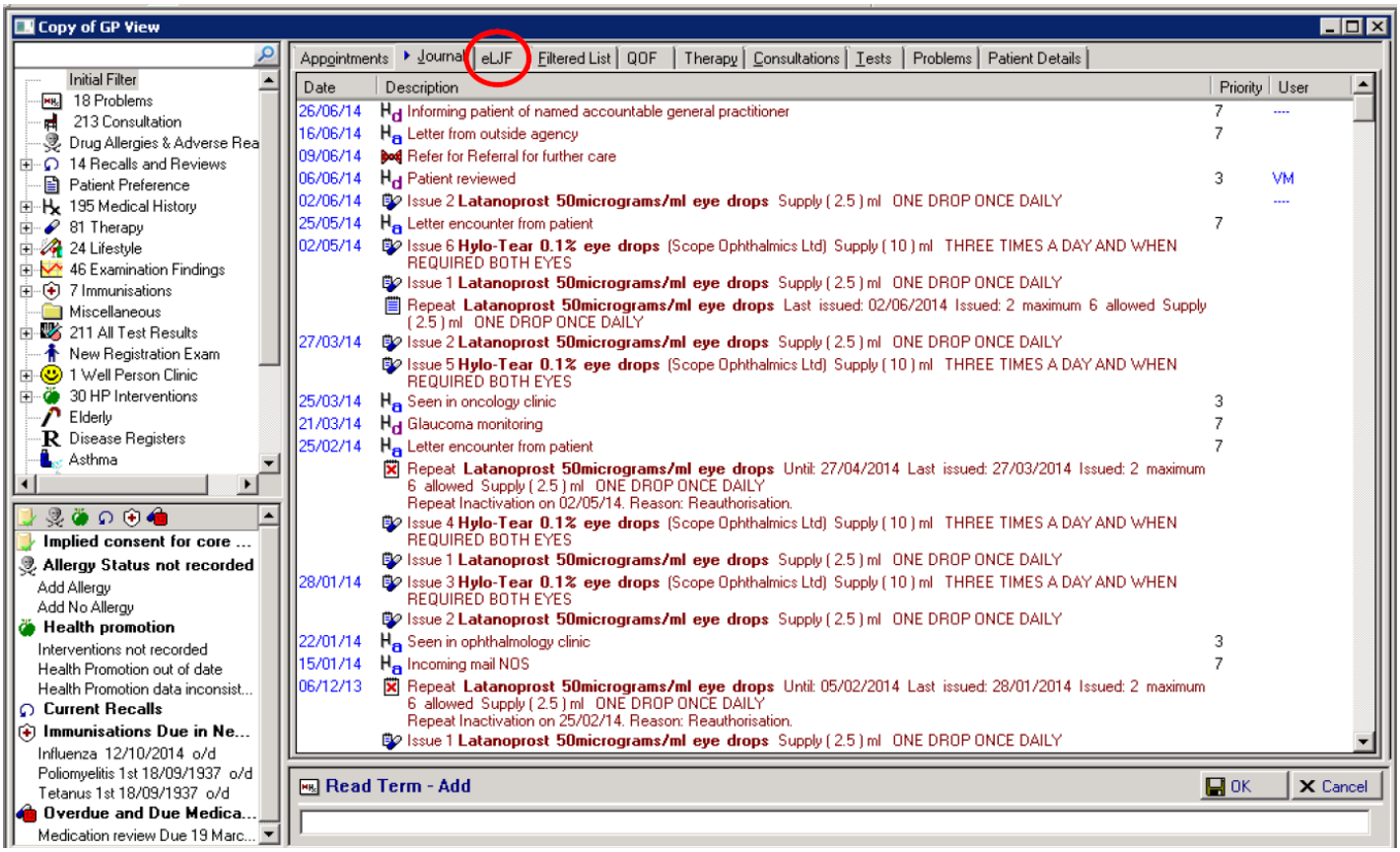
A quick 6-step tutorial has been devised to demonstrate six of the most beneficial features of using eLJF-CLINICAL whilst consulting. The tutorial can be used as a self-guided tool or as a script for a demonstration. A pdf and PowerPoint presentation of the Quick 6-step tutorial is hosted on the LJF website. The hope is that once these six skills are mastered this will lead to wider use of eLJF-CLINICAL while doing patient-facing work. Using eLJF-CLINICAL can prevent awkward fumbling through the BNF or trying to access the internet on over-stretched computers.

The fundamental first step is to identify that you can access eLJF-CLINICAL from the patient consultation screen. Is there a tab to eLJF (see illustration)? This has to be set up for **every** user individually. If there is no tab, contact your IT lead in the practice or the GMS facilitator team.

The tutorial includes the following steps:

ONE	Check version
TWO	Prescribe LJF first choice
THREE	Use the 'GO' button
FOUR	Look for 'Prescribing notes'
FIVE	Use 'short code' prescribing
SIX	Prescribe for a child

There may be the option to include completion of the 'Quick 6-step tutorial' as part of a medicines management GMS action, on discussion with your Primary Care Pharmacist. Equally it could be submitted as a CPD activity for appraisal.



Supplement: Recent SMC and Lothian Formulary Committee Recommendations

The supplements can be accessed via the LJF website www.ljf.scot.nhs.uk in 'Prescribing Bulletins'.

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