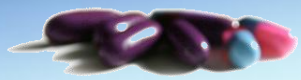
LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

NHS Lothian

In this issue …



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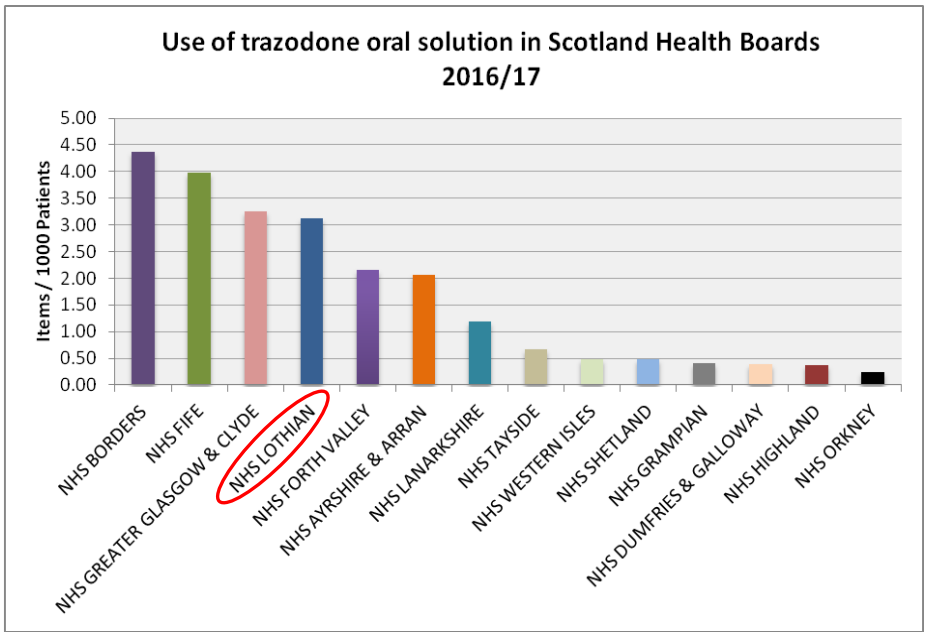
Is trazodone the best choice for your patient?

Trazodone is indicated for the treatment of depressive illness, particularly where sedation is required, and anxiety. It is not an antidepressant of choice in the LJF, but may be useful in the management of agitation, irritability and at times aggression in older people.[1] A review by the Cochrane Dementia and Cognitive Improvement Group concluded that studies involving more subjects were required to determine if SSRIs, trazodone, or other antidepressants are safe and effective treatments for agitation and psychosis in dementia.[2]

Where clinical use of trazodone is appropriate, capsules and tablets are the preferred formulations[1] but the solution may be appropriate for patients who have difficulty swallowing, following an assessment by a speech and language therapist. The preferred sedating antidepressant for patients with swallowing difficulties is mirtazapine, as orodispersible tablets. Therefore, trazodone oral solution should be prescribed only for patients where there is no suitable alternative, and when prescribed by a secondary care clinician for new patients a non-formulary medicine request form should be completed.



The cost of trazodone oral solution has increased significantly; the current cost for 120mL 50mg/5mL is £146.[3]
A significant amount of prescribing continues to occur in NHS Lothian (see graph).

Key messages:

- **Patients should be regularly reviewed to establish whether there is any benefit from continued prescribing of trazodone.**
- **Trazodone oral solution should only be prescribed for patients with swallowing difficulties where there is no suitable alternative.**

References

1. Lothian Joint Formulary www.ljf.scot.nhs.uk
2. Seitz DP *et al*. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011, Issue 2. Art. No.: CD008191. DOI: 10.1002/14651858.CD008191.pub2 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008191.pub2/full *Accessed 27.06.17* [Athens login required]
3. Scottish Drug Tariff. Part 7. June 2017. www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/Drugs-and-Preparations-with-Tariff-Prices.asp

Quality improvement in community pharmacy

Talking about 'quality and safety' is like talking about 'fruit and apples'. Safety cannot be divorced from quality.
Don Berwick, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Dispensing error reporting is low within community pharmacy. It is thought that this is due to the fear of criminalisation, as dispensing errors are strictly liability offences. This means that a criminal offence is committed even if the error itself is unintentional and regardless of the level of patient impact. The Berwick Review makes the point that fear is toxic to both safety and improvement.[1]

Ongoing work on the rebalancing of pharmacy legislation seeks to ensure the right balance between government legislation and professional regulation. With the proposed changes to the defence for inadvertent dispensing errors this fear will be removed. As a result, an increase in both reporting and learning is expected, which will lead to improvements in patient safety while encouraging responsible development in practice.

Improvements in the recording of internal errors and near misses with associated action and learning will require behavioural change within community pharmacy. A just, open, safe and fair culture will be underpinned by quality improvement.

A recent Scottish Government communication[2] advised community pharmacy contractors and NHS Boards of steps to strengthen and embed continuous quality improvement. A priority is for community pharmacy teams to complete a Safety Climate Survey by 30 September 2017. Staff should discuss the results in an open and supportive way, and should use the findings to identify areas for improvement.

The NHS Lothian community pharmacy champions are available to support any member of community pharmacy staff who has questions about this work. See NHS Community Pharmacy Scotland website for contact details.

References
1. Independent Report. Berwick Review into Patient Safety. Department of Health. 6 August 2013. www.gov.uk/government/publications/berwick-review-into-patient-safety
2. Pharmaceutical Services Supporting Continuous Improvement and Closer Partnership Working. NHS Circular: PCA (P)(2016) 15. The Scottish Government. 16 September 2016. www.sehd.scot.nhs.uk/pca/PCA2016(P)15.pdf

Thanks to Dawn Owen, Lead Pharmacist Community Pharmacy Development for contributing this article.

LJF update

Miconazole for thrush in breastfeeding mothers and infants

The LJF has been updated in line with new local guidance to support the correct diagnosis and treatment of thrush infection, usually caused by Candida albicans, in breastfeeding mothers. It is recommended that mother and baby are treated simultaneously, even if there are no oral lesions visible in the baby's mouth.

Prescribing will take place mainly in primary care by midwives, infant feeding advisors and GPs.

A prescribing note for the use of miconazole 2% **cream** (Daktarin®) has been added to adult section 13.10.2 for the **treatment of breast and nipple thrush in lactating women** link. The off-label use relates to increased frequency of application.

The use of miconazole 2% **oral gel** (Daktarin®) for the **treatment of oral thrush in breastfed infants** has been extended to include those under four months of age – see child section 5(e) ENT link. This off-label use has been approved by the Lothian Neonatal and Paediatric Drug and Therapeutics Committee. Miconazole oral gel is not licensed for use in children under four months or during first five to six months of life in an infant born pre-term.

Depot antipsychotic guidelines reinforce importance of needle length

The NHS Lothian Depot Antipsychotic Guidelines[1] have been reviewed and updated in line with current practice.[2] The review was prompted by a significant event involving a patient who was found to have subtherapeutic levels of depot medication due to selection of the wrong needle length resulting in the drug failing to reach the muscle layer (the patient was overweight).

The guidelines now include advice on selecting the correct equipment for administration. It is important to reinforce that if a depot antipsychotic injection is provided in a pack alongside a syringe and needle, the syringe and needle provided must always be used.

Where the needle is not supplied with the product, then the needle length (i.e. not the gauge) is the most important consideration.

A variety of needle lengths are available and assessment of the length of needle required to reach the muscle should be made on an individual patient basis taking into account any subcutaneous fat.[2]

A clinical decision may be required regarding the choice of depot antipsychotic injection if there are concerns about delivery of the drug. This should be discussed with the patient's consultant psychiatrist and a change in depot antipsychotic injection may be required.

Key points

- **Where syringes and needles are supplied in the pack with the depot antipsychotic injection, *the syringe and needles provided must always be used*.**
- **Consider reviewing needle length in all patients receiving depot antipsychotic medicines.**

***'Understanding Your Depot Injection'* cards for patients can be ordered via PECOS, order code PCT 067.**

References

1. Depot Antipsychotic Guidelines. NHS Lothian. December 2016. Available on the Intranet [link]
2. Feetam C. & White J. Eds. Guidance on the Administration to Adults of Oil-based Depot and other Long-Acting Intramuscular Antipsychotic Injections 5th Edition (2016) available at www.hull.ac.uk/injectionguide. *Accessed 23/06/17*

Thanks to Zarah Swain, Specialist Clinical Pharmacist, for contributing this article.

Report Illicit Drug Reactions (RIDR)

Potentially serious risks to public health can arise from the use of New Psychoactive Substances (NPS) (previously known as 'legal highs'), however there is a lack of evidence about the long term harms. A UK-wide 12-month pilot project 'Report Illicit Drug Reactions' (RIDR) was introduced by Public Health England (PHE) and the Medicines and Healthcare products Regulatory Agency (MHRA) in March 2017 with the aim of improving clinical understanding of emerging drug harms and to reduce the length of time between the emergence of drug-related health harm and the dissemination of effective treatment responses.[1]

The RIDR project involves an online reporting system based on the existing Yellow Card Reporting Scheme, involving health professionals completing a form. It is important to note that this does not replace the Yellow Card Scheme and suspected reactions to licensed medicines, including those due to misuse or abuse, should continue to be reported using this system.

The Scottish Government encourages participation in the pilot as wide contribution will help build a database of effective interventions to help colleagues who are providing care to these patients, sometimes in very challenging circumstances.[2]

References

1. Report Illicit Drug Reactions (RIDR). Public Health England. https://report-illicit-drug-reaction.phe.gov.uk/
2. Reporting reactions to illegal drugs – using the reporting illicit drug reactions (RIDR) system. Letter from Chief Medical Officer, Chief Pharmaceutical Officer, Chief Nursing Officer. The Scottish Government. 22 March 2017.

Thanks to Chris Miller, Lead Pharmacist for Substance Misuse and Prison Services for contributing this article.

Managing spironolactone or eplerenone with ACEis or ARBs – the how-to guide

In LPB Issue 84 we highlighted the need for caution with combinations of mineralocorticoid receptor agonists (MRAs) such as spironolactone or eplerenone with angiotensin converting enzyme inhibitors (ACEis) or angiotensin receptor blockers (ARBs) when used to treat patients with severe heart failure. SIGN 147[1] and a recent Drugs and Therapeutics Bulletin (DTB)[2] have offered pragmatic advice on how to manage patients who require addition of an MRA to an ACEi or ARB.

Initiation

- Spironolactone (or eplerenone) should only be started if serum potassium is <5.0millimoles/L and serum creatinine is <221micromoles/L.
- Start with a low dose of MRA. Spironolactone 25mg daily (or 25mg on alternate days if poorly tolerated); eplerenone 25mg once daily.
- Avoid potassium supplements unless the patient's serum potassium levels are <3.5millimoles/L.[3]
- Avoid potassium sparing diuretics, 'low salt' substitutes with a high potassium content, potassium-rich diets and NSAIDs.

Monitoring

- Check urea, creatinine, electrolytes and eGFR at one, four, eight and 12 weeks; six, nine and 12 months; six monthly thereafter.[1,2,4]
- If serum potassium rises to 5.5millimoles/L or creatinine rises to 220micromoles/L, reduce the dose of MRA to 25mg on alternate days. If already on 25mg alternate day therapy then withhold the MRA.
- If serum potassium rises to, or above 6.0millimoles/L or creatinine rises to 310micromoles/L, stop the MRA immediately and seek specialist advice.

Prescribing notes

- Be particularly alert to renal failure or hyperkalaemia when drug changes are instigated in a patient already on spironolactone or eplerenone. The MHRA received a report of fatal hyperkalaemia within two weeks of a patient on spironolactone starting lisinopril 2.5mg.[5]
- Patients should be provided with written advice on sick day rules.[6]
- Patients should be advised to stop their MRA if prescribed a course of trimethoprim and to be alert to other potential drug interactions.
- The DTB article[2] suggested that few patients with severe heart failure who are also taking an ACEi or ARB would be expected to tolerate more than 25mg spironolactone daily as up to one in five have been found to develop hyperkalaemia. This may also apply to eplerenone so caution is recommended with either MRA.

References

1. Management of Chronic Heart Failure. Scottish Intercollegiate Guidelines Network. Guideline 147 (Annex 5). March 2016. www.sign.ac.uk/sign-147-management-of-chronic-heart-failure.html *Accessed 27.06.17*
2. Spironolactone – Potion or Poison? Drug Ther Bull 2017; 55(2):14-17. http://dtb.bmj.com/content/55/2/13?hwoasp=authn%3A1497711220%3A4130224%3A1056932570%3A0%3A0%3AXY2NSSA%2Fy%2FsJ0SRBBLHPEw%3D%3D [Athens login] *Accessed 27.06.17*
3. Summary of Product Characteristics (Aldactone) www.medicines.org.uk
4. Chronic Heart Failure in Adults: management. Clinical guideline [CG108]. National Institute for Health and Care Excellence. www.nice.org.uk/guidance/cg108/chapter/1-guidance *Accessed 27.06.17*
5. Spironolactone and renin-angiotensin system drugs in heart failure: risk of potentially fatal hyperkalaemia. Drug Safety Update. Last updated 14 December 2016. Medicines and Healthcare products Regulatory Agency. www.gov.uk/drug-safety-update/spironolactone-and-renin-angiotensin-system-drugs-in-heart-failure-risk-of-potentially-fatal-hyperkalaemia *Accessed 27.06.17*
6. Medicine Sick Day Rules Card. Scottish Patient Safety Programme. www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/medicine-sick-day-rules-card

Supplements:

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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