PostScRxipt – PrimaRxy Care

JUNE 2007

SAFETY OF ROSIGLITAZONE: The New England Journal of Medicine (www.nejm.org) has published a study raising concerns about the possibility of a small increased risk of MI and cardiovascular death in patients treated with rosiglitazone. Patients with diabetes are at an increased risk of cardiovascular disorders and glitazones may cause fluid retention, which can make some heart problems worse or lead to heart failure. Warnings about this risk have been present in the product information since launch in 2000. In 2006, following a comprehensive review of trial data, the product information was updated to reflect more fully the risk of heart failure and to include a warning about the potential small increased risk of myocardial infarction. This review considered data from most of the studies that were included in the NEJM paper.

- Prescribers are reminded to adhere to the restrictions for use in patients with cardiac disease as set out in the SPC (http://www.medicines.org.uk/).
- Patients should not stop treatment with rosiglitazone but should discuss their medication with their doctor at their next routine appointment.

07/08 STATIN INDICATOR: One of this year's prescribing indicators is "% of *Formulary* choices for all prescribing in BNF 2.12 and simvastatin as % of all statins". The following drugs are the *Formulary* choices.

- Atorvastatin, pravastatin, simvastatin
- Bezafibrate, fenofibrate, colestyramine
- Ezetimibe (not including Inegy®)

There are small differences between the *Clyde Formulary* and *Glasgow Formulary*, so appeals will be accepted for Clyde practices after the year end where the differing Formulary status has affected achievement.

PRESCRIBING INDICATORS ON PRISMS: These are available under GGC local reports on the PRISMS front page. There are two queries for each indicator, a Health Board summary and a practice version. To run the query hit the refresh button and choose the appropriate variables. You will be able to run these queries for any time period so you can get month to month updates if required. Please **DO NOT** save these queries to your personal documents but always run them from the PRISMS front page to make sure that the most up to date versions are being used.

CONTROLLED DRUG DESTRUCTION: Last month's bulletin highlighted the legislative change in management of CDs. One responsibility of the new Accountable Officer function will be to arrange for CD destruction. Details will be circulated as soon as the processes have been finalised. Until then, remember:

- Patient CD returns should be directed towards the pharmacy that supplied them. It is not necessary to have an **authorised** witness, but is good practice for a member of staff to witness destruction by the pharmacist and to document such destructions, eg in the private script book.
- Authorised witnesses for destruction in community pharmacies are RPSGB or police chemist inspectors.
- GP practices should store out of date CDs appropriately until the new service is in place.

Any GP practice having **exceptional** difficulty with this interim arrangement should contact the Prescribing Team for advice.

NEW PRESCRIPTION FORMS: NSS Practitioner Services will not process version 3 of prescription forms after 1st July 2007. Version 4 has a box for the signature of people collecting controlled drugs. Old forms should be returned to the Board for destruction, new forms can be ordered from Practitioner Services in Livingstone.

GENERIC CALCIPOTRIOL OINTMENT: We noted last month that Dovonex® ointment was being discontinued. There is now a generic calcipotriol ointment 120g available.

ESOMEPRAZOLE PRESCRIBING AUDIT

There are currently five proton pump inhibitors (PPIs) available and two of these, omeprazole and lansoprazole, are included in the *Formulary*. PPI prescribing is included as one of the MED 10 prescribing indicators for GPs.

A recent review of usage and expenditure figures for PPIs raised concerns that esomeprazole may be being initiated and used inappropriately. To provide more detailed information, a small audit was undertaken within two acute hospital sites in Glasgow. Any patient commenced on, or admitted on, oral esomeprazole in the general medical and surgical wards were included. Thirty-two in-patients were identified during the 8-week study period. The study found that:

- 81% were taking esomeprazole prior to admission.
- 19% of patients were started on esomeprazole during the study.
- Full details regarding therapy were difficult to obtain for the patients who were admitted on esomeprazole.
- Information on who initiated therapy was unknown for nine (28%) patients.
- 41% of patients were started on esomeprazole in secondary care.
- 31% of patients were started on esomeprazole in primary care. It was not always known if this was on the advice of a secondary care specialist.
- Most patients (78%) had been treated with at least one other PPI before commencing esomeprazole treatment.
- The most common reason for prescribing esomeprazole was that the PPIs tried initially were ineffective in controlling symptoms (53%).

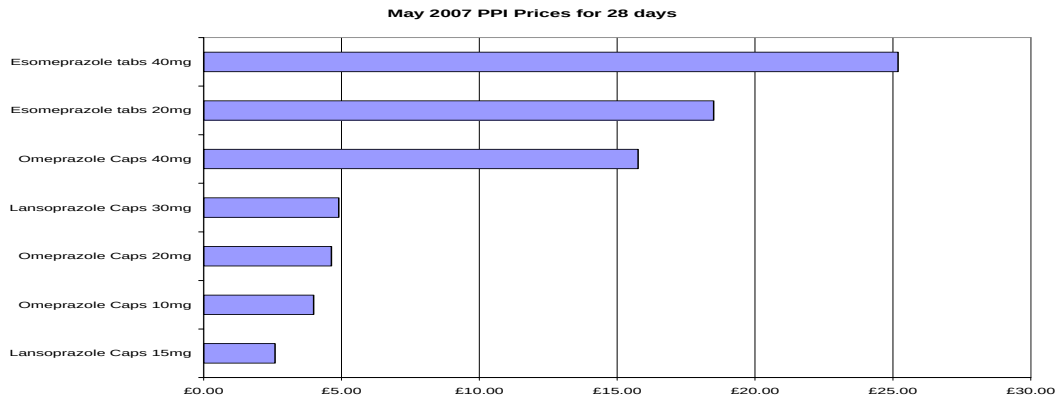
A continuation of the study in out-patients found similar results. The main reason for use was that the PPIs tried initially were ineffective in controlling symptoms (83%)

In Renfrewshire, an audit was carried out on 100 patients taking esomeprazole. Data on 93 evaluable patients showed:

- Average use was 1.7 years.
- Daily doses for esomeprazole: 24% on 20mg, 61% on 40mg and 15% on 80mg.
- Just over half were initiated by secondary care, with around half of those initiated by consultants.
- In 31% of cases esomeprazole was prescribed for an unlicensed condition, eg benign gastric or duodenal ulcers.
- 8% of patients received esomeprazole as first line treatment.

SUMMARY

- There is limited prescribing of esomeprazole, usually as a second or third line agent.
- Initiation occurs within both the primary and secondary care settings.
- GPs who prescribe esomeprazole or who are asked to prescribe it by specialists should question why the *Formulary* options, omeprazole and lansoprazole, are not suitable.
- *Formulary* PPIs have a wider range of licensed indications than esomeprazole.
- All patients on PPIs should have their treatment regularly reviewed to ensure that therapy is still indicated and the lowest dose that controls symptoms is prescribed.
- For a review of the use of PPIs and a summary of the evidence base see *PostScript Extra* April 2006 at www.glasgowformulary.scot.nhs.uk/.



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