PostScRxipt – PrimaRxy Care

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CLOPIDOGREL AND PPIs Statement from the Heart MCN: The EU Committee for Medicinal products for Human Use (CHMP) and its Pharmacovigilance Working Party has concluded that concomitant use of proton pump inhibitors (PPIs) and clopidogrel should be discouraged since PPIs may reduce the efficacy of clopidogrel in reducing thrombotic events. Large studies (observational data)*, however, have shown no difference in mortality between those on clopidogrel + PPI and those on clopidogrel and no PPI.

Please note that PPIs are used widely and reduce the likelihood of gastric bleeding with both aspirin and clopidogrel (a side effect of their use and with a significant adverse outcome especially in the acute coronary event).

There are several scenarios.

Some cardiologists will recommend switching from a PPI to an H2 antagonist (ranitidine) when commencing clopidogrel, or indeed when reviewing a patient already on clopidogrel and a PPI. Many will not. The variation is because there is as yet such a poor evidence base for risk. Advice is to follow the recommendation of the individual consultant. However for all patients with a DES or on limited term clopidogrel following an acute coronary episode, it is generally agreed that if ranitidine does not control upper GI symptoms satisfactorily, it is better to re-commence a PPI than to stop the clopidogrel before the recommended time period, on the balance of risks and benefits.

For those on clopidogrel because of true intolerance to aspirin, the same applies. It is better to continue the clopidogrel with a PPI than stop clopidogrel if ranitidine does not control upper GI symptoms

There is no reason to consider a formal switching programme in general practice, for those on clopidogrel, from PPI to ranitidine.

The EMEA statement indicates that no individual PPI is more or less likely to interact with clopidogrel than any other.

- Prescribers should continue to follow the local antiplatelet guideline for patients with indications for the combination of aspirin and clopidogrel.
- Prescribers should avoid the use of a PPI with clopidogrel if possible.

* JAMA. 2009;301(9):937-944

SUNSCREEN: Sunscreen may be prescribed under ACBS criteria for specified conditions. These are abnormal cutaneous photosensitivity resulting from genetic disorders or photodermatoses (including vitiligo and those resulting from radiotherapy), chronic and recurring herpes simplex labialis. The Formulary Preferred List sunscreen (E45 Sun®) has recently been discontinued. This will be replaced by Sunsense® Ultra in the next revision of the formulary.

MANAGEMENT OF INFECTION GUIDANCE FOR ADULTS

New Guidelines for the management of infection in adults have been approved by the Area Drug and Therapeutics Committee and have been circulated electronically to all primary care prescribers and community pharmacists.

The importance of improving the prescribing of antimicrobials in primary care and acute care has recently been raised both nationally and locally. The 2008 Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP) outlines the national programme for Scotland in tackling antimicrobial resistance and prudent prescribing over the next five years in both acute and primary care. The government paper CEL(30)2008 states that 'the Antimicrobial Management Team (AMT) should cover primary and secondary care prescribing activities'. More recently the government has also set HEAT targets relating to reducing the incidence of *C.Difficile* and staphylococcal bacteraemias. The need for implementing and monitoring best practice guidelines in primary care was recommended locally in the independent Outbreak Control Team report following the *C.Difficile* associated mortalities at the Vale of Leven last year. Further information on the AMT can be found in Postscript No.44 .

The aims of this new guidance are to:

1. Provide information on the most clinically and cost effective use of antimicrobials for treatment of infection in adults.
2. To minimise the emergence of bacterial resistance and *Clostridium difficile* in the community.

PRINCIPLES OF PRUDENT PRESCRIBING:

- **Prescribe an antibiotic only when there is likely to be a clear clinical benefit.** If in doubt consider delayed prescribing.
- **Do not prescribe an antibiotic for viral sore throat, simple coughs and colds.**
- **Limit prescribing over the telephone**
- **Use simple, narrow-spectrum, generic antibiotics** whenever possible.
- **The use of certain antibiotics (eg co-amoxiclav, quinolones, clindamycin and cephalosporins) is inappropriate when standard and less expensive antibiotics remain effective**. These agents increase the risk *of Clostridium difficile*, MRSA and multi-resistant UTIs. Macrolides are also associated with an increased risk of MRSA.
- **Prolonged antibiotic therapy** also increases risk of adverse events, including *Clostridium difficile*
- **Patients at high risk of *Clostridium difficile*** are those > 65years, previous antibiotic therapy in the past 2 months, contact with patients with *Clostridium difficile*, and recent hospital admission.
- **Avoid widespread use of topical antibiotics** (especially those agents also available as systemic preparations).

The new guideline is available from: www.ggcformulary.scot.nhs.uk under 'Guidelines Store'.

One of the Rational Prescribing Indicators for the current year is: DDDs/1000weighted patients per quarter should be less than or equal to 1950.
Ways to reduce DDDs:

- Ensure prescribing for infections is in accordance with the new guideline by drug choice, dose and duration of course
- Only prescribe when likely to be clinical benefit
- Devise a practice policy on handling requests for antibiotics
- Reinforce education to patients and staff that not all infections require antibiotics eg viral
- Use delayed prescribing when appropriate eg persistent otitis media, persistent respiratory symptoms etc
- Encourage patients to utilise the Community Pharmacy minor ailment service for immediate symptomatic treatment

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