PostScRxipt – PrimaRxy Care

November 2009

ORAL THRUSH TREATMENT OPTIONS FOR INFANTS: There are two options listed in the *Formulary* for the treatment of oral candidiasis in babies. The lower age limit for each of these medicines is different:

NYSTATIN SUSPENSION: licensed for children from one month of age. 100,000units four times daily, usually for seven days.

The department of Health website (www.dh.gov.uk) states that Community Practitioner nurse prescribers may exceptionally prescribe nystatin off-label for neonates if they are:

- ✓ certain that the diagnosis is oral candidiasis
- ✓ aware that they accept medico-legal and clinical responsibility for prescribing the medicine
- ✓ practicing within their own competence.

MICONAZOLE (DAKTARIN®) GEL: licensed for children from four months of age. 2.5ml twice daily until 48 hours after lesions have healed (BNF for children advises same dose for babies from one month but this is unlicensed). GPs and pharmacists should provide information on the unlicensed status of miconazole to parents of babies aged one to four months to reassure them.

ASPIRIN – NO LONGER RECOMMENDED FOR PRIMARY PREVENTION: The MHRA have recently provided advice on the indications for aspirin (Drug Safety Update – October 2009). This article advises that aspirin is only licensed for secondary prevention of vascular events. Recent studies had shown that the risks of gastrointestinal bleeds outweighed the small reduction in risk of a cardiovascular event. The MHRA advises that if aspirin is used for primary prevention that the balance of risks and benefits should be considered on a patient by patient basis.

NHS Greater Glasgow and Clyde

Locally NHS Greater Glasgow and Clyde current antiplatelet guidelines are to be reviewed in light of these recent studies.

GELATIN IN FERROUS TABLETS: It has been highlighted recently that all ferrous fumarate solid oral dose formulations contain gelatin. Prescribers and community pharmacists should be aware of this where a change from ferrous sulphate to fumarate is being carried out. Some patients may choose not to consume gelatin for religious or dietary reasons.

NICORANDIL SIDE EFFECT: A rare side effect of nicorandil which prescribers should be aware of is ulceration of the peri-anal area. Patients with this adverse effect of nicorandil are often treated for pressure sores before the underlying cause is identified. If this occurs, patients should ideally have the nicorandil stopped and an alternative prescribed. Ulcers usually heal quickly once nicorandil is stopped.

ORCIPRENALINE – UK WITHDRAWAL: The Commission on Human Medicines (CHM) have reviewed the risk-benefit profile of orciprenaline (Alupent®) and have advised that it should be withdrawn from the UK market over the next year. This review concluded that orciprenaline had an increased incidence of cardiac side effects and was less effective both in extent and duration of bronchodilation compared to salbutamol.

Inhaled formulations of beta-2 agonists are more effective and have fewer side effects than oral formulations. However oral formulations provide an alternative for patients who cannot manage the inhaled route. Prescribers should review patients who are currently prescribed orciprenaline at the next available opportunity and change to a more selective bronchodilator such as salbutamol or terbutaline.

Salbutamol Soln 2mg/5ml	£1.60/150ml*
Bricanyl Syrup 5mg/5ml	£2.00/100ml**

* Scottish Drug Tariff – Nov 2009 ** BNF Sept 2009

CONTROLLED DRUG INSTALMENT PRESCRIPTION WRITING GUIDANCE

Although the regulations around writing of instalment prescriptions has not changed; in recent months there has been a stricter interpretation of the legislation around the use of dose and instalment amounts. The way that prescriptions have generally been written up until now does not meet the legal requirement to have **both** the dose and instalment amount included. This applies to any schedule 2 or 3 Controlled Drug (CD) issued by instalments, eg MST. Screenshots are available under documentation: http://www.staffnet.ggc.scot.nhs.uk/Acute/Division%20Wide%20Services/Pharmacy%20and%20Prescribing%20Support%20Unit/Controlled%20Drug%20Inspection%20Team/Pages/default.aspx.

The full agreed Home Office wording should be used for supply when a pharmacy is closed, missed doses and supervision. As it is not possible to fit the information onto currently available GP systems, stamps have been ordered which contain the relevant information. These will be sent from your CH(C)P. For further advice on the legal requirements of prescription writing please contact the Controlled Drug Governance Team (0141 201 5348) or your local Addictions Team (Glasgow Addictions Service (0141 276 6600).

METHOTREXATE: Recently NHS Quality Improvement Scotland highlighted the patient safety messages within the BNF regarding oral methotrexate. Prescribers are reminded that methotrexate, for the management of rheumatoid arthritis and psoriasis, should be administered once a week and that only one strength of methotrexate (**usually 2.5mg**) should be prescribed and dispensed.

The patient should be carefully advised of the dose, frequency and the reason for taking methotrexate and any other prescribed medicines (eg folic acid). Prescribers should warn patients to immediately report the onset of any feature of blood disorder (eg sore throat, bruising and mouth ulcers), liver toxicity (eg nausea, vomiting, abdominal discomfort, and dark urine) and respiratory effects (eg shortness of breath).

The Greater Glasgow and Clyde Formulary (August 2009) states that oral methotrexate should only be prescribed as 2.5mg tablets to avoid patient confusion. The dose should be clearly specified on the dispensing label.

Please ensure that patients are prescribed only one strength (ideally 2.5mg) of methotrexate tablets.

REVISED NICE GUIDANCE ON ESCITALOPRAM: Mental Health Drug and Therapeutic Committee's view on NICE guidance; Depression in Adults (90) with focus on Escitalopram.
NICE issued an update to their Depression in Adults Guideline (No. 90) in October 2009; contained within this is a review of escitalopram. The summary of the findings are as follows:

1) Escitalopram is superior to placebo and the 20mg dose is probably more effective than 10mg but at the cost of increased side effects
2) Escitalopram is at least as effective as other antidepressants but is no better tolerated than sertraline
3) Differences in effect that favour escitalopram versus other SSRIs are not thought to be clinically significant
4) There is no evidence of additional benefit versus venlafaxine and duloxetine
5) Cost of escitalopram remains high compared with other antidepressants (escitalopram £25.20 for 20mg, citalopram £1.44 for 40mg, fluoxetine £1.02 for 20mg*, all 28 day supplies BNF No.58, September 2009)

The usage of escitalopram has escalated within NHSGG&C over recent months. It is the view of the Mental Health Drug and Therapeutics Committee that Escitalopram is a high cost antidepressant with **no observable clinical benefit** over existing formulary choices of antidepressants (fluoxetine and citalopram are first line options). Therefore it should not be used within the existing antidepressant algorithm. Escitalopram remains non-formulary within NHSGG&C.

*The 60mg strength of fluoxetine is not cost effective (£55.76 for 28 capsules), therefore a dose of 60mg should be prescribed as fluoxetine 20mg take three capsules daily (£3.06 for 28 days).

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