PostScRxipt – PrimaRxy Care

September 2010

SUSPENSION OF ROSIGLITAZONE

The MHRA recently published guidance on restricted prescribing of rosiglitazone (Avandia®) in view of the evidence of association with cardiovascular risk. Two recent studies (Graham et al JAMA 2010; 304(4): 411-418 and Nissen & Wolski Arch Inter Med 2010; 170(14): 1191-1201) have shown further evidence of increased cardiovascular events in patients on rosiglitazone compared to pioglitazone, insulin and other oral hypoglycaemic agents. The risks appear greater when rosiglitazone is used in combination with insulin.

A European Medicines Agency review of the evidence has concluded that rosiglitazone should be suspended across the European Union as the benefits do not outweigh the risk. This comes into affect over the next few months and will remain unless convincing data can be supplied by the marketing authority to identify a patient population in whom the benefits would outweigh the risks.

Prescribers are required to

- Stop prescribing rosiglitazone containing medications (Avandia® and Avandamet®).
- Identify and review all patients on rosiglitazone and consider changing to an alternative on an individual basis.
- The Diabetes MCN would recommend pioglitazone 15-45mg once daily be considered as a direct thiazolidinedione alternative for patients who do not have evidence of contraindications namely heart failure, weight gain, or ankle oedema.‡
- Alternative second/third line treatment recommendations would be a sulphonylurea, gliptin (DPP-IV inhibitor) or GLP-1 agonist (exenatide, liraglutide) with standard precautions

CHOLESTEROL GUIDELINES:

The new NHSGGC Lipid Guidelines have recently been approved by the ADTC and are now available on the ADTC website and staffnet.

Changes to previous version:

- Ezetimibe is no longer recommended and has been removed from the Formulary

Primary prevention

- No longer recommends re-testing lipids after statin initiated as no target

Secondary prevention

- Removal of atorvastatin 80mg for Acute Coronary Syndrome

FORMULARY SECTION REVIEW: ANTICHOLINERGICS FOR URINARY FREQUENCY AND INCONTINENCE:

A recent multidisciplinary review of section 7.4.2 of the GGC Formulary took place involving urologists, GPs and specialist pharmacists. Several changes to the Formulary were recommended, and these have subsequently been endorsed by ADTC. The main changes to the Formulary are as follows:

- Section 7.4.2 of the Preferred List now consists of oxybutynin standard release, solifenacin and tolterodine.
- Fesoterodine has been added as a choice in the Total Formulary in addition to oxybutynin modified-release, and oxybutynin patches.
- Darifenacin and trospium have been removed from the Formulary
- Duloxetine has been moved from the Preferred List to the Total Formulary and changed to specialist initiation.
- A prescribing note for solifenacin has been added: most patients will respond adequately to the lower 5mg dose, which should be trialled for 6-8 weeks before considering a dose increase.
- A prescribing note for oxybutynin has been added: oxybutynin should be used with caution in older patients following evidence of potential cognitive impairment.
- A general prescribing note for antimuscarinics has been added: when prescribing antimuscarinics, consideration should be given to other factors which may influence the patient's condition and response to treatment (e.g. excessive intake of fluid and other lifestyle choices).

MEDICINES MANAGER LES Practices have recently been sent information about a new local enhanced service and asked to identify a non-clinical member of staff to undertake the role of 'medicines manager'. The individual will be given training in medicines management including; reducing waste of medicines and aligning quantities to a standard period of supply. Training, provided by members of prescribing support, starts in mid October to be completed by early December.

SINEMET SHORTAGE: Sinemet® is in short supply worldwide in relation to a manufacturing issue. Normal supplies are expected by 2011. The information below is a guide on equivalent medications. Sinemet® comes in different tablet sizes. It is important to select the correct equivalent strength. Three options are described:

OPTION 1. GENERIC EQUIVALENTS OF SINEMET. Sinemet® 62.5, Sinemet® 110, Sinemet Plus®, and Sinemet® 275 can usually be changed to generic co-careldopa at an equivalent strength. Half Sinemet® CR or Sinemet® CR can be changed to generic modified release co-careldopa preparations at equivalent strength (see table below).

OPTION 2. MADOPAR® OR CO-BENELDOPA AS SUBSTITUTES. If the above cannot be obtained, Madopar® or co-beneldopa can be used. Although it is rare to be intolerant of Madopar® or co-beneldopa, and manage on Sinemet® or co-careldopa, a quick check with the patient (or GP) is prudent.

Sinemet®	**Co-Careldopa Equivalent**	**Madopar® Equivalent**	**Co-beneldopa Equivalent**
Sinemet® 62.5	Half of a tablet of co-careldopa 25/100	Madopar® 62.5	Co-beneldopa 12.5/50
Sinemet® 110	Co-careldopa 10/100		
Sinemet® Plus	Co-careldopa 25/100	Madopar® 125	Co-beneldopa 25/100
Sinemet® 275	Co-careldopa 25/250		
Half Sinemet® CR	Caramet ®CR (co-careldopa 25/100 MR)	Madopar® CR 125	Co-beneldopa 25/100 MR
Sinemet® CR	Two Caramet® CR(ie 2 co-careldopa 25/100 MR) *or* co-careldopa 50/200 MR (Lecado® MR is another brand name)	Two capsules of Madopar® CR 25/100	

OPTION 3. ADJUST OVERALL MEDICATION. If no immediate release or CR preparations equivalent to Sinemet® are available, other options can be tried depending on the patient's drug regime.

Example A. If the patient is on entacapone, or there is an indication for this to be started, a combined levodopa / DCI / entacapone preparation can be used (Stalevo®).

Example B. If the patient is on a mix of immediate and controlled release preparations there may be an option to simplify the regime without using CR preparations.

These options are more complex and it may be helpful for these to be discussed with the Parkinson's nurse or PD specialist clinic where appropriate.

Sinemet taken with Entacapone 200mg	**Stalevo® Equivalent**
Sinemet® 62.5	Stalevo® 50
Sinemet® 110	Stalevo® 100
Sinemet® Plus	Stalevo® 100

Although Sinemet Plus® is the equivalent of two tablets of Sinemet® 62.5, Stalevo® 100 is **not** the equivalent of two tablets of Stalevo® 50. This is because each Stalevo® tablet contains 200 mg of entacapone. Pharmacies should try to obtain generic co-careldopa through wholesalers and directly from MSD (01992 467272).

‡The PROactive study (Wilcox et al. AM Heart J 2008; 155(4): 712-7) showed a small decrease in major cardiovascular events in patients with type 2 diabetes compared to placebo.

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