PostScriptPrimaryCare

NHS Greater Glasgow and Clyde

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This edition contains articles on

- HAI and antibiotic resistance priorities
- Antimicrobial use in older people
- Paracetamol overdose risk
- Disulfiram short supply
- Stoma accessories and underwear
- Renal dysfunction, MRAs and chronic heart failure
- Diagnosing coeliac disease in children
- Primary Care clinical guidelines

Scottish Government Healthcare Associated Infection and Antibiotic Resistance Priorities: Revision of Primary Care Prescribing Measure

Reduction in the healthcare associated infections *Clostridium difficile* and *Staphylococcus aureas* bacteraemia continues to be a national priority. Instances of out of hospital *C. difficile* infection now account for > 50% of cases. To date, quinolone variance has been used as the primary care indicator Boards are measured on. In recognition of the concern over the continued increase in antibiotic volume in primary care (up 3.4% in 2011), this will be replaced from June 13 with a total volume target. This requires that by March 2015, 50% of GP practices in a Health Board are below the Scottish lower quartile (as at January to March 2013), or have significantly moved towards this figure. To support this work within NHSGGC, antibiotic volume will continue to be a prescribing indicator offered to appropriate practices. Locally, indicators measuring quinolones, cephalosporins and co-amoxiclav will also remain. Educational and audit resources are available for these indicators via the Prescribing Support Teams.

Antimicrobial use in older people

The Scottish Antimicrobial Prescribing Group (SAPG) has recently produced 'Good Practice Recommendations for Antimicrobial Use in Older People', plus a useful 'Decision Aid for Diagnosis and Management of Urinary Tract Infection (UTI)'. Although many of the principles are applicable to all patients, they are particularly relevant to older people who are at increased risk of adverse effects, healthcare associated infection, and infection due to resistant organisms. Some key recommendations are:

- Give careful consideration to clinical benefits and risks before prescribing, especially in those at end of life
- In catheterised patients and older people, the likelihood of UTI should be determined by the presence of appropriate signs and symptoms of infection
- Dipstick testing of urine is not recommended for diagnosing UTI in older people or catheterised patients as bacteriuria is often present in the absence of infection (send culture as required if symptoms indicate infection)
- Long term antibiotics for UTI prophylaxis promotes resistance and their clinical need should be reviewed after 6 - 12 months (exclude post-menopausal vaginal atrophy resulting in symptoms suggestive of UTI)

Paracetamol overdose risk

A Fatal Accident Inquiry in 2011 concluded that an underweight adult died of liver failure due to the prescribing of an accidental overdose of intravenous paracetamol. In his report the sheriff concluded there was *'a prevailing culture of assumed familiarity with the administration of intravenous paracetamol, a familiarity derived from the common use of oral paracetamol. That assumed familiarity was misplaced.'*

Prescribers should be aware that the dose of **oral** paracetamol may also need to be reduced. The NHSGGC Therapeutic Handbook 2012 advises prescribers should "consider dose reduction in patients with low body weight (< 50kg), renal / hepatic impairment or glutathione deficiency (chronic malnourishment, chronic alcoholism) to 15 mg/kg/dose up to four times daily (max 60mg/kg/day)". A dose reduction may be particularly relevant for frail, elderly patients.

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Disulfiram short supply

There is a current shortage of disulfiram (Antabuse®) 200mg tablets. An alternative product, disulfiram (Esperal®) **500mg** tablets, is unlicensed in the UK but may be supplied on a named patient basis.

The 500mg tablet is double scored allowing doses of 125mg, 250mg, 375mg or 500mg, but is not currently listed on EMIS PCS or INPS Vision and prescriptions will have to be handwritten for '500mg disulfiram tablet (Esperal)' with a suitable dose (see Addiction Services guidance for suggested dose conversion table). If the prescriber does not feel converting the dose is within their competence, they should contact their local addiction team for advice.

Please contact the patient's pharmacy prior to writing the prescription to determine whether the pharmacy still has any licensed stock and ensure they are willing to procure the 500mg unlicensed product.

A translated Patient Information Leaflet (PIL) is currently available, and patients with queries can also be referred to their local pharmacist.

Additional information and updates on the current stock position will be provided when available. Please contact Jennifer Torrens (0755 701 2870) or other members of the Addiction Pharmacy Team on 0141 277 7660 if you require any further details or have any queries.

Stoma accessories and underwear

The NHSGGC ScriptSwitch® message database contains information messages linked to stoma accessories and underwear. In the majority of patients, accessories and stoma underwear are not required but may be requested by patients. For example, deodorants should not be prescribed: a household air freshener is sufficient. Stoma accessories or underwear should only be prescribed on the advice of an NHS Colorectal/Stoma Clinical Nurse Specialist.

Renal dysfunction, MRAs and chronic heart failure (CHF)

There has recently been concern raised by primary care about CHF patients with significant renal dysfunction being started on a mineralocorticoid receptor antagonist (MRA) such as spironolactone or eplerenone.

Renal dysfunction is common in CHF, especially in the cohort of patients who are indicated for an MRA (ie symptomatic patients with moderate to severe LV impairment). As such, the use of MRAs in CHF patients with renal disease is well established. The EMPHASIS (eplerenone) study only excluded patients with an eGFR <30ml/min and approximately one third of the total study population had an eGFR <60ml/min. The RALES (spironolactone) study only excluded patients with a serum creatinine concentration >221 µmol/l.

As such, MRAs can often be considered in appropriate patients with eGFRs ≥30ml/min. This should be following specialist advice. Detailed advice on how to use MRAs and problem solve with renal function worsening and/or hyperkalaemia can be found in SIGN Guideline 95 'Management of chronic heart failure'. Practices are advised to be vigilant that all CHF patients newly started on a MRA are followed-up as per the specifications of the Near Patient Testing LES. Advice on the renal dysfunction with MRAs in CHF patients can also be sought from the HF specialist nurse team and the HF specialist pharmacist if required (contact details in local NHSGGC HF guidelines).

New Guidelines for the Diagnosis of Coeliac Disease in Children

A new guideline for the diagnosis and management of coeliac disease in children has been published by the British Society of Paediatric Gastroenterology, Hepatology and Nutrition and Coeliac UK.

Previously all children suspected of having coeliac disease and on a normal gluten containing diet underwent an upper GI endoscopy with biopsies to confirm the diagnosis. Now symptomatic children who have a level of IgA transglutaminase antibodies greater than 10 times the upper limit of normal and/or a positive endomysial antibody on 2 separate blood tests and who are human leukocyte antibody (HLA) DQ2 or HLA DQ8 positive can have the diagnosis of coeliac disease confirmed on blood tests alone.

All children with suspected coeliac disease should still be referred to a Paediatric Gastroenterologist. The new guideline means that some children will now have their diagnosis confirmed on their serology alone and these patients will be eligible for prescribable gluten free items.

Primary Care clinical guidelines

The following primary care guidelines have been posted on the Clinical Guideline Electronic Resource Directory:

- Vitamin D measuring and prescribing: osteoporosis and osteomalacia
- Primary care prescribing guidelines for oral nutritional supplement for adults

Click **HERE** for the full list of May additions.

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