PostScRxipt – PrimaRxy Care

October 2011

NPSA PATIENT SAFETY ALERT: LITHIUM THERAPY UPDATE: The June bulletin provided details of the plans to distribute NPSA lithium packs. Due to unforeseen logistical problems the planned distribution of the information packs in June/July was delayed. These packs are now being distributed to GP Surgeries, Community Pharmacies, Hospital Pharmacies and Mental Health Staff.

Each NPSA pack contains a patient information booklet, lithium alert card and a patient held record book for tracking blood tests. The packs are intended to reduce the likelihood of harm to patients due to inappropriate dosing related to irregular blood lithium-level testing by presenting relevant information to patients and staff. In addition, if patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely. It is recommended by the NPSA that at the start of lithium therapy and throughout treatment, patients receive appropriate ongoing verbal and written information and a record book to track lithium blood levels and relevant clinical tests. It is the view of the Mental Health Partnership Clinical Governance Executive Group, Drugs and Therapeutics Committee & Prescribing Management Group that the booklet and card be issued to all patients but that use of the patient held monitoring record is optional.

An introductory letter restating these aims is enclosed with the NPSA packs as is a Statement of Good Practice for lithium therapy from The Prescribing Management Group (Mental Health) which draws heavily from both the NPSA Alert and current NICE Guidelines (CG38: Bipolar Disorder).

NO FREE LUNCH – WORKING WITH INDUSTRY: We would like to encourage practices to reflect on the offer of any free service from the pharmaceutical industry particularly where there is an obvious conflict of interest when considering initiating patients on drug therapy.

NHS Greater Glasgow and Clyde

We have recently identified industry funded activity which is at odds with local guidance and expert opinion which included decision making based on read codes without discussion or assessment of the patient.

The risk of agreeing to a tick box list of criteria is that patients may be wrongly medicalised and initiated on medication inappropriately. **The prescribing team and your practice pharmacist can offer advice on any such proposals including how they fit with local guidelines and policies.**

VARENICLINE & NRT: We have been made aware that some practices have been prescribing both nicotine replacement therapy (NRT) and varenicline together for patients for smoking cessation. Varenicline is a partial nicotine receptor agonist and thus co-prescribing nicotine products along with this would be unlikely to be beneficial. Prescribing the combination of these products is not supported in NICE public health guidance 10 or the NHSGGC smoking cessation guidelines.

TACROLIMUS PRESCRIBING: The March 2011 bulletin contained information on prescribing of immunosuppressants for renal patients. The article advised that patients should not be prescribed tacrolimus or ciclosporin generically; all prescriptions for these drugs should be written by brand name.

We have been asked about the prescribing of these drugs for other patient groups.

It is good practice to prescribe both tacrolimus and ciclosporin by brand name as switching formulations may lead to changes in blood concentrations. Switching should only be undertaken with close therapeutic monitoring by a transplant specialist.

Supervision of methadone and reduced methadone-related deaths

Opiate Substitute Therapy (OST) has a strong evidence base for effectiveness in individuals with heroin dependency, including a much reduced mortality rate. NICE recommends methadone as the "first choice" drug for OST (**NICE Technology Appraisal Guidance 114)** and it remains the mainstay of OST in Greater Glasgow and Clyde. However, methadone itself can contribute to a significant risk of overdose, most often when used in combination with other prescribed or non-prescribed drugs. Of particular significance is increased risk of respiratory depression and death when used in combination with other opiates, benzodiazepines, and alcohol. Over the last decade, Scotland has witnessed an increase in the numbers of such methadone related deaths. In GGC, the majority of these deaths tend to occur in individuals with a known history of drug misuse who are currently not in treatment. These individuals are likely to have consumed methadone diverted from prescriptions for patients in treatment.

Supervised dispensing of methadone in community pharmacies is recommended for at least a three month stabilisation period by the **UK Guidelines on Clinical Management of Drug Misuse 2007** (pages 50-52)**.** Supervision ensures compliance and regular contact with a service. It minimises the leakage and diversion of prescribed methadone. A recent study in the **BMJ (Strang et al. 2010)** added to the evidence that increased supervision of methadone is also related to reduced methadone related mortality. In NHSGGC, supervised doses are recommended beyond the stabilisation period.

In an effort to minimise methadone related mortality in NHSGGC, all prescribers are reminded of their responsibility to minimise the risk of diversion of methadone through ensuring appropriate levels of supervised dispensing at pharmacies. Full guidance on this can be found in the **GGC Addiction Services Prescribing Guidelines and Practice Standards** (pages 7-8), http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Addictions/Pages/GGLK19052008.aspx

In summary, the key principles are:

- Methadone carries potentially fatal risks to children and non-opiate dependent adults at relatively lower doses. There is, in addition, risk of prosecution to those supplying methadone illicitly. It is therefore of paramount importance that when prescribing methadone, patients be advised of these risks and reminded of their responsibility to ensure their take-home doses are not diverted to others.
- The dangers of poly-substance misuse should be discussed.
- Giving advice on the safe storage of methadone at home to ensure safety of children and others (leaflets available through GAS pharmacy team)
- **Methadone oral solution 1mg/1ml** should be the preferred formulation used rather than sugar free or more concentrated forms and tablets.
- Reserving take home doses for individuals able to evidence stability and where daily pharmacy attendance becomes a barrier to progress (e.g. employment/education) and **reviewing this on a regular basis.**
- Giving consideration to late opening pharmacies for those working and where concerns around compliance, safe storage and/or diversion arise for patients in employment.
- Giving consideration to 6 or 7 day opening pharmacies where concerns arise.
- Refer patients at risk of overdose to local **'take home' naloxone training** and supply programs
- Consider **Suboxone® as an alternative**. The combination of Buprenorphine (partial opiate agonist) and Naloxone (opiate antagonist) makes it a relatively safer drug. ***FOR MORE INFO*** *see guidelines and contact Glasgow Addiction Services if considering prescribing.*

For further guidance or queries, please contact **Glasgow Addiction Services (GAS) at 0141-276-6600**. ***Key Contacts:*** *Dr. Saket Priyadarshi, Lead Clinician. Carole Hunter, Lead Pharmacist. Dr. Tony Martin, Drug Death Research Associate.*

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