PostScriptPrimaryCare

NHS Greater Glasgow and Clyde

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Low Dose Naltrexone (LDN)

Naltrexone is an opioid-receptor antagonist which is used as an adjunct to prevent relapse in formerly opioid-dependent patients. It has also been used in low doses of 3 to 4.5mg, which is a specially made formulation, for management of symptoms of multiple sclerosis (MS) (unlicensed use).

The UK Medicines Information Service has recently published a question and answer document of the evidence for the use of low dose naltrexone (LDN) in MS. In summary:

- Small pilot studies have shown that LDN is a relatively safe and well tolerated drug in people with MS and can improve some symptoms. However, a randomised, double blind, placebo controlled trial needs to be performed to fully assess the efficacy and safety of the drug.
- There is no published long term data on efficacy and safety of LDN when used for MS.
- One study did not find any evidence of incompatibility between LDN and interferon beta. LDN may block the analgesic effects of opioid drugs and they should not be used together.
- If LDN is used to treat MS, both the indication and product formulation are unlicensed.
- If LDN is taken, a positive beneficial response to LDN cannot be assured or guaranteed.
- **There is not enough evidence based information to prove LDN is an effective treatment for MS.**

Novel Oral Anticoagulants

NHS guidance states that patients with non-valvular atrial fibrillation (AF), who are believed to be complying with warfarin therapy but who have a poorly controlled INR should be considered for a novel oral anticoagulant (NOAC). A poorly controlled INR for this purpose is defined as therapeutic less than 60% of the time. Recent guidance from the Heart Managed Clinical Network (MCN) states that these patients will be identified by the Glasgow and Clyde Anticoagulation service (GCAS) who will contact the patient's GP to suggest consideration of a switch to one of the NOACs. The guidance provides information on factors which should be considered when making the decision to change to a NOAC and the choice between the three agents.

We have been made aware of industry employed "interface" pharmacists contacting practices offering to review AF patients and to identify patients suitable for switching to particular NOAC drugs. Practices are strongly encouraged to decline such offers and follow the advice from GCAS.

The role of NOACs in the management of new patients has been under consideration and the Heart MCN is undertaking a review of the NHSGGC AF guideline. This will include a change which will support the option of prescribing a NOAC as a first-line alternative to warfarin where anticoagulation is indicated in patients newly diagnosed with non-valvular AF. The *Formulary* status of dabigatran and apixaban has been updated to reflect this change. The position for rivaroxaban is unchanged and is in line with SMC advice.

Chronic Non-Malignant Pain Opioid Guidelines – Updated

The updated NHSGGC Chronic Non-Malignant Pain Opioid Guidelines are now available in the Clinical Guideline Repository on StaffNet.
The guideline contains information on:

- Assessing for appropriateness of a trial of opioid treatment
- Need for regular assessment and review
- Choice of opioid and maximum recommended doses
- Opioid dose equivalences
- When to consider referral to pain clinic

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Reducing Prescribing of Hypnotics and Anxiolytics

While it is recognised as good clinical practice to review patients on regular anxiolytic or hypnotic therapy with a view to withdrawal, it is recognised that there are some exclusion criteria which would make a stepwise reduction inappropriate. Exclusion criteria include (not exhaustive):

- Patients experiencing current crisis or illness requiring on going prescription
- Patients with severe mental health problems or prescribing by a psychiatrist
- Patients receiving benzodiazepines for management of epilepsy
- Patients with a chronic or acute condition where benzodiazepine is used to relieve muscle spasm
- Patients who are substance misusers attending community addiction team

For other patients there may be a need for caution when changing current treatment including (not exhaustive):

- Patients who are seriously ill or receiving palliative care
- Previous failed attempt at step down
- Where there is the potential for drug-drug/pharmacodynamic interactions.
- Patients with Parkinson's Disease (PD) – PD specialist advice should be sought. Anxiety and sleep disturbance (often multifactorial, including REM sleep behaviour disorder) are very common, non-motor complex symptoms in PD and may be modulated by benzodiazepines. The interaction between dopaminergic and GABAergic neurones is complex and not fully understood.

Methotrexate and trimethoprim interaction

Concurrent administration of trimethoprim and methotrexate has been reported to cause haematological toxicity. Information available on the interaction is limited and the mechanism is not fully established but is thought to be due to the additive inhibition of dihydrofolate reductase by trimethoprim and methotrexate. Although there are several case reports of this interaction in the published literature, the duration of trimethoprim therapy prior to the bone marrow suppression occurring is not always stated. There is information to suggest that it can occur as soon as two days after commencing trimethoprim as well as after long term use. Therefore there is a risk of a clinically significant interaction with short courses of trimethoprim of 3-7 days duration. This would also apply to co-trimoxazole.

Depression Treatment Guideline

The Depression Treatment in Primary Care Guideline for NHSGGC has been revised. The guideline aims to bring together non-pharmacological and pharmacological management within a NHSGGC context. The main changes are to remind prescribers:

- In general, increasing SSRI doses in depression does not improve efficacy. Daily doses: ***'50's enough'*** for sertraline and ***'20's plenty'*** for fluxoxetine or citalopram to assess initial response.
- If patients are compliant with therapeutic antidepressant doses they should see some improvement within two to four weeks.
- More prescribing information has been included when treating patients with co-morbidities and to address common prescribing questions.

Vitamin B_{12} injections prescribing guidance

Hydroxocobalamin is the preferred form of vitamin B_{12} as it is retained longer in the body than cyanocobalamin and can be given at intervals up to 3 monthly for maintenance. Hydroxocobalamin injection is available as a pack of 5 vials and is subject to over-ordering and a high degree of waste.

To minimise waste and reduce the likelihood of over-ordering, practices may wish to consider a policy of:

- Prescribing a quantity of 1 vial on repeat
- Adding the frequency of injection to the dose instructions on prescription
- Prescribe as acute rather than repeat

Education of staff handling repeat prescription requests could also ensure that prescriptions are not issued before necessary.

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