3 SETS OF NEW GUIDELINES APPROVED

PostScRxipt
from the
NHSGGC Area Drug & Therapeutics Committee
Issue 49 January 2009

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Website
http://www.ggcformulary.scot.nhs.uk

1 Cardiovascular disease

The Heart Managed Clinical Network and ADTC have approved a range of updated guidelines (see our website for full details) covering the following areas:

- Antiplatelet use
- Atrial fibrillation
- Hypertension
- Left ventricular systolic dysfunction
- Management of cholesterol

These are based on existing guidelines but have been harmonised for use across NHSGGC and to promote a consistent approach for all aspects of cardiovascular disease (CVD) management and prevention.

There are two strategies for primary prevention of CVD:
1 The population strategy aims to reduce risk factors at a population level through lifestyle and environmental changes affecting everyone without requiring medical examination of individuals. This is mostly achieved by health improvement.
2 Individual level primary prevention (the 'high risk approach') seeks out apparently healthy individuals and estimates their CVD risk, eg JBS2 score. Interventions are made in those at higher risk by encouraging health-related behaviour change and pharmacological management of raised cholesterol and blood pressure.

NHSGGC has well established primary prevention strategies for CVD. These are available for everyone throughout the Board area who needs some support to change health-related behaviours without risk assessment.

Individual level primary prevention is currently unsatisfactory. Various guidelines have defined different levels of 'high risk' and some practitioners are not using any formal risk assessment and are treating on the basis of a single risk factor, such as smoking or high cholesterol value.

What is the new NHS Greater Glasgow & Clyde policy on primary prevention?

- To continue to develop, improve and strengthen population-level primary prevention.
- To encourage referral, for everyone who needs and wants them, not just those with a high risk score, to services supporting health-related behaviour change, eg:
  - Smokefree smoking cessation services,
  - Live Active for the sedentary,
  - Eat Up for healthy eating advice,
  - Shape Up and GCWMS weight management services.
- To support opportunistic risk assessment (as opposed to a systematic screening or case finding approach) to identify patients eligible for pharmacological intervention.
- To support consistent practice between primary and secondary care by encouraging practice based on the revised local guidelines.
- To ensure a consistent threshold (30% CVD risk over 10 years) for pharmacological intervention to prevent CVD in individuals.
- To support the use of a formal algorithm for assessing risk rather than treating on individual risk factors. The preferred tool is the JBS2 risk calculator until the ASSIGN score has been evaluated through Keep Well.
- To advise tackling all risk factors (blood pressure, cholesterol and smoking), unless any is particularly high as defined in the new guidelines.
- To implement fully the local enhanced services (LES) for secondary prevention of CVD in primary care. Please note, there is currently no CHD LES in Renfrewshire CHP, and no stroke LES anywhere in Clyde.
- To keep policy under constant review in the light of local and national policy changes.

2 Neuropathic pain

The ADTC has approved new guidelines for the management of neuropathic pain and for osteoarthritis (OA) of the hip and knee. They will be added to our website once the final versions are printed.

Neuropathic pain is defined as "pain initiated or caused by a primary lesion or dysfunction of the nervous system". The signs and symptoms of neuropathic pain are not relieved by rest and may include burning, throbbing, electric shocks/ spasms, tingling or numbness. Examples of different types of neuropathic pain are:

- post-herpetic neuralgia,
- diabetic neuropathy,
- trigeminal neuralgia,
- nerve root pain.

Simple analgesia and NSAIDs are seldom effective. The first line option is treatment with either a tricyclic antidepressant, eg amitriptyline, or the anti-epileptic drug gabapentin. In general, prescribers are advised to "start low and go slow" so that the dose escalation minimises side effects. Second line treatment is usually with an opioid such as tramadol or morphine.

Patients should be counselled about the chronic nature of most neuropathic pain states. The duration of treatment

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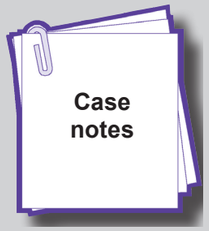
For all article references, check our website www.ggcformulary.scot.nhs.uk

Alphabetical list of most recent ADTC decisions

For full details of SMC advice, visit **www.scottishmedicines.org** For NICE advice, visit **www.nice.org.uk** For previous ADTC decisions, visit **www.ggcformulary.scot.nhs.uk**

Drug	Indication under consideration (There may be other licensed indications)	NHSGGC decision	
Alemtuzumab (MabCampath®)	Treatment of patients with B-cell chronic lymphocytic leukaemia for whom fludarabine combination chemotherapy is not appropriate.	Ⓢ Total *Formulary.* Acknowledge new indication. Restricted to use in accordance with regional protocol.	✓R
Ambrisentan (Volibris®)	Treatment of patients with pulmonary arterial hypertension classified as WHO functional class II and III, to improve exercise capacity.	Ⓢ Total *Formulary.* Restricted to initiation and prescribing by specialists in the Scottish Pulmonary Vascular Unit and the Scottish Adult Congenital Cardiac Service.	✓R
Anidulafungin (Ecalta®)	Treatment of invasive candidiasis in adult non-neutropenic patients.	Ⓢ Total *Formulary.* Restricted to use only on the advice of consultant microbiologist where other treatment options are unsuccessful or inappropriate.	✓R
Aripiprazole (Abilify®)	Rapid control of agitation and disturbed behaviours in patients with schizophrenia when oral therapy is not appropriate.	Ⓢ Total *Formulary.* Acknowledge new formulation. Restricted to use by consultant psychiatrists.	✓R
Atazanavir (Reyataz®)	Treatment of antiretroviral treatment naïve HIV-1 infected adults, in combination with other antiretroviral medicinal products.	Ⓢ Total *Formulary.* Acknowledge new indication. Restricted to use by HIV specialists where other treatments are inappropriate.	✓R
Bivalirudin (Angiox®)	Treatment of adult patients with acute coronary syndromes (unstable angina/non-ST segment elevation myocardial infarction) planned for urgent or early intervention.	Non-*Formulary.*	x
Bosentan (Tracleer®)	Treatment of pulmonary arterial hypertension WHO functional class II.	Non-*Formulary* for this indication.	x
Flecainide (Tambocor XL®)	Treatment of AV nodal reciprocating tachycardia, arrhythmias associated with Wolff-Parkinson-White Syndrome and similar conditions with accessory pathways; paroxysmal atrial fibrillation in patients with disabling symptoms when treatment need has been established and in the absence of left ventricular dysfunction.	Ⓢ Total *Formulary.* Acknowledge new formulation.	✓
Icatibant (Firazyr®)	Symptomatic treatment of acute attacks of hereditary angioedema in adults (with C1-esterase-inhibitor deficiency).	Non-*Formulary.*	x
Insulin glulisine (Apidra®)	Treatment of adolescents and children, 6 years or older with diabetes mellitus, where treatment with insulin is required and for whom the use of a short-acting insulin analogue is appropriate.	Total *Formulary.* Acknowledge new indication. Restricted to use in patients where soluble insulin is inappropriate.	✓R
Insulin lispro (Humalog® KwikPen)	Treatment of adults and children with diabetes mellitus who require insulin for maintenance of normal glucose homeostasis, and for the initial stabilisation of diabetes mellitus.	*Formulary* (Preferred List). Acknowledge new presentation.	✓
Insulin lispro and insulin lispro protamine (Humalog® Mix25, Mix50 KwikPen)	Treatment of patients with diabetes mellitus who require insulin for maintenance of normal glucose homeostasis, for whom treatment with this biphasic insulin analogue is appropriate.	*Formulary* (Preferred List). Acknowledge new presentation.	✓
Ketoprofen gel (ADTC Formulary Section Review)	Pain associated with osteoarthritis of the hip and knee.	Total *Formulary.*	✓
Micafungin (Mycamine®)	Treatment of invasive candidiasis in adults, elderly and children (including neonates).	Non-*Formulary.*	x
Miconazole (Loramyc®)	Treatment of oropharyngeal candidiasis in immunocompromised patients.	Non-*Formulary.*	x
Pemetrexed (Alimta®)	Monotherapy for the second-line treatment of patients with locally advanced or metastatic non-small cell lung cancer other than predominantly squamous cell histology.	Ⓢ Total *Formulary.* Acknowledge new indication. Restricted to use in accordance with regional protocol.	✓R
Piroxicam gel (ADTC Formulary Section Review)	Pain associated with osteoarthritis of the hip and knee.	Total *Formulary.*	✓
Quetiapine (Seroquel XL®)	Treatment of schizophrenia and manic episodes associated with bipolar disorder.	Ⓢ Total *Formulary.* Acknowledge new formulation. Restricted to initiation by consultant psychiatrists.	✓R
Rituximab (MabThera®)	Treatment of previously untreated patients with stage III to IV follicular lymphoma in combination with chemotherapy.	Ⓢ Total *Formulary.* Acknowledge new indication. Restricted to use in accordance with regional protocol.	✓R
Rufinamide (Inovelon®)	Adjunctive therapy in the treatment of seizures associated with Lennox-Gastaut syndrome in patients aged four years and older.	Ⓢ Total *Formulary.* Restricted to specialist initiation.	✓R

✓ =*Formulary* ✓R =*Formulary* (restricted) **x** =non-*Formulary* **?** = awaiting final decision Ⓢ =specialist initiation only Ⓢ =specialist use only



Nebulised ipratropium and acute angle closure glaucoma

What happened?

In March 2008 a patient was admitted to a Glasgow hospital with an exacerbation of chronic obstructive pulmonary disease. He was commenced on nebulised ipratropium and salbutamol via face mask and was discharged home on nebulised therapy three weeks later with Respiratory Early Supported Discharge nurse home follow-up. After being at home for a week, the patient developed visual problems. The respiratory nurse specialist assessed the patient, the nebulised therapy was discontinued, treatment was discussed with the GP and an urgent ophthalmology appointment was made. The patient was diagnosed with acute angle closure glaucoma and given appropriate treatment which successfully reversed the condition without any further incident.

Could this have been predicted?

The MHRA Drug Analysis Print (see **www.mhra.gov.uk**) January 1977-October 2008 lists 557 adverse reactions to ipratropium including 27 reports of glaucoma. The BNF notes: "Acute angle-closure glaucoma reported with nebulised ipratropium… care needed to protect patient's eyes from nebulised drug or from drug powder." The SPC provides more details about this possible effect and states that care must be taken not to allow the solution or mist to enter the eyes.

What is the local guidance for COPD?

The NHSGGC *Formulary* Preferred List contains both ipratropium and tiotropium. The COPD guidelines are available on our website. Since tiotropium is used once daily, adherence may be better. Improved adherence may lead to better control resulting in less need for nebulised therapy. There is no benefit to adding ipratropium where patients are already receiving tiotropium. The NHSGGC *Therapeutics Handbook for Prescribers in Acute Care* lists nebulised salbutamol as the first line option with ipratropium indicated where there is a poor response to salbutamol.

PRACTICE POINTS

- **Glaucoma is an uncommon but recognised side effect of ipratropium.**
- **The risk may be increased when nebulised ipratropium bromide and beta$_2$-agonists are administered simultaneously.**
- **Care must be taken not to allow the product to enter the eyes. Where possible, the nebulised solution should be administered via a mouthpiece. If this is not available and a mask is used, the mask must fit properly.**
- **Patients who may be predisposed to glaucoma should be warned specifically to protect their eyes.**
- **There are almost 6,000 prescriptions in primary care for nebulised ipratropium per year. Patients should be reviewed to ensure treatment remains appropriate and that the method of administration minimises the risk of adverse effects.**

3 Adult asthma

The Board's Respiratory Planning Group has recently launched the new NHSGGC adult asthma guideline. Here, Dr Nigel Pexton explains the rationale behind developing the guideline and a summary of its contents. The full document is available on our website.

The BTS/SIGN Asthma Guideline is widely accepted as the UK standard for care. The latest version was published in 2003 and revised in 2008. Although an essential reference, it extends to 120 pages so is less useful as an 'on the spot' aid in a consultation. The GP contract requirements for asthma care are limited; a particular criticism is that although 'annual review' is included, there is little to guide practices in ensuring reviews provide a high standard of care and benefit patients. The Respiratory Planning Group hopes that the NHSGGC Adult Asthma Guideline will assist as a brief summary of the current BTS/SIGN guideline, and prove useful during consultations.

The diagnosis of asthma is mainly clinical, primarily obtained from the history. It ideally requires quantitative confirmation, particularly in view of the possibility of long-term treatment. Spirometry is now the preferred method, but peak flow remains acceptable. Importantly, both are far from infallible.

The key points of stepwise management are a low threshold for introducing preventive therapy, but with an awareness that doses of the main preventive treatment, inhaled corticosteroids (ICS), should be kept as low as possible. In adults, the addition of a long acting beta agonist (LABA) is the accepted next stage, even at relatively low doses of ICS, eg 400mcg beclometasone daily. We strongly recommend the use of combination inhalers; there have been deaths associated with patients talking LABAs without concurrent ICS.

The guideline uses the Royal College of Physicians' 'Three Key Questions' to try to identify the common under-reporting of symptoms:

1 Have you had difficulty sleeping because of your asthma symptoms - including cough?
2 Have you had your usual asthma symptoms during the day - cough, wheeze, chest tightness or breathlessness?
3 Has your asthma interfered with your usual activities - housework, work, school etc?

There are other, perhaps better validated, asthma symptom questionnaires available, but these are familiar and included on the SPICE screens on GP practice systems. (For details of the Scottish Programme for Improving Clinical Effectiveness in Primary Care (SPICE), see **www.spice.scot.nhs.uk**)

Some common clinical issues are highlighted with a checklist to aid in these situations; compliance, notably with preventive treatments, is well recognised as a challenge. There is hope that providing simple goal-centred action plans, personalised to the patient's own preferred outcomes, may play a part in addressing this. Personalised Asthma Action Plans are grade A in terms of evidence, but do not have to be (and usually should not be) complex standardised documents.

A clinical framework for annual review is provided which can be easily entered on SPICE screens if available. The important peak flow measurement is the patient's personal best, rather than the predicted value. Checklists are given for complicating problems (asthma often co-exists) and when to refer. However most, but not all, asthma can be managed solely in primary care.

We finish with two reminders;
1 Not all inhaled steroids are equipotent; even different formulations of the same drug may not be equivalent. As adrenal suppression, osteoporosis and even death have been associated with injudicious doses of steroids, it is important to be aware of the differences and dose ranges.
2 If the patient cannot use the inhaler provided, even the best asthma prescribing will be rendered useless.

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2 Neuropathic pain *contd from page 1*

depends on the level of improvement, but withdrawal of treatment after significant improvement may be considered every six months with careful review. If treatment does not result in improvement, referral to acute care should be made.

OA is a likely diagnosis where the patient suffers morning stiffness for less than 30 minutes, the pain worsens later in the day and 'gelling' of the knees occurs (stiffness developing shortly after sitting). It is not essential to have an X-ray for diagnosis. Early referral to a rheumatologist should be considered for patients under 50 years of age, with systemic upset suggestive of gout, connective tissue disease or septic arthritis, or where morning stiffness lasting more than 60 minutes suggests an inflammatory arthritis.

The first-line treatment option in OA is paracetamol, possibly with the addition of a topical NSAID. Piroxicam and ketoprofen gels have recently been added to the Total *Formulary*. There are several topical NSAID preparations available, but these products are listed in the Scottish Drug Tariff and carry significant cost benefits.

The second-line options are changing paracetamol to co-codamol, co-dydramol or adding tramadol. Oral NSAIDs may also be considered at this stage. If this treatment fails, options include addition of amitriptyline, conversion to a strong opioid or referral to an orthopaedic surgeon, a rheumatologist or a pain clinic.

NHS Greater Glasgow and Clyde

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