UPDATED UNLICENSED MEDICINES POLICY FOR THE ACUTE DIVISION

PostScRxipt
from the
NHSGGC Area Drug & Therapeutics Committee
Issue 53 September 2009

The ADTC has recently approved an update to the unlicensed medicines (ULMs) policy. The full document will be placed under the Board policies section on Staffnet. The policy aims to provide guidance surrounding the use of ULMs/off-label medicines within the acute services division as this is an area of high risk.

Medicines with the appropriate Marketing Authorisation (MA) should be used to treat patients in preference to unlicensed or off-label medicines whenever possible. However, use of ULMs/off-label medicines may be necessary in order to provide the optimum treatment for patients. They should only be prescribed if their use can be clearly justified from a clinical/pharmaceutical perspective. In some specialties, such as paediatrics, many medicines are prescribed off label due to lack of MA in the paediatric setting. The decision to prescribe ULMs and off-label medicines is the responsibility of the consultant in charge of the patient's care.

A cornerstone of the policy is that an appropriate clinical risk assessment should be carried out whenever a clinician wishes to use a ULM/off-label medicine. Consideration should be given to the evidence base, the risks/benefits to the patient or patient group in the proposed setting and peer group opinion.

All medicines have side-effects which may vary with the indication being treated. This should be considered when prescribing off label as there may be new and unforeseen consequences if only used rarely in this setting. In the case of ULMs, the level of knowledge about product quality, efficacy and side-effects will frequently be lower than for medicines used within an MA. Knowledge may be minimal if the medicine is used early in its development. Within the scope of this policy; it is considered that all ULMs should be considered high risk medicines. Suggested criteria for risk assessment of off-label medicines are shown in the table below.

Where it is intended that either ULMs or off-label treatment will be continued after patient discharge, clear arrangements MUST be agreed between primary and secondary care regarding clinical, prescribing and dispensing responsibilities. The hospital consultant who has initiated treatment is responsible for ensuring that the relevant GP is given sufficient information. A decision on final responsibility should depend primarily on the best interests of the patient in terms of safety and convenience. However, GPs are at liberty to refuse to prescribe within primary care if their concerns cannot be resolved after communication with secondary care.

The policy is supported by a 'Frequently Asked Questions' document which can also be accessed via Staffnet.

In this issue . . .

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

Low risk	Medium risk	High risk
Few significant side effects.		• Teratogenic • Carcinogenic • High risk of life threatening or disabling side effects • Cytotoxic
Established generally, eg listed in BNF, SIGN guidelines, BNF for Children.	• Established use in specialty, eg specialist published guidelines. • Phase III/IV clinical trial data published in established journals.	• Biological agent • Phase I/II clinical trial data, abstracts of phase III/IV clinical trials or case reports published in established journals.
Oral/external/nasal subcutaneous/respiratory.	Intravenous or installation into cavity or bone.	• Intrathecal • Epidural

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	
Calcipotriol and betamethasone dipropionate scalp gel (Xamiol®)	Topical treatment of scalp psoriasis.	Total *Formulary*. Acknowledge new formulation.	✓
Cocodamol 15/500 (Codipar®) (ADTC Appeal)	Post-operative pain.	Non-*Formulary*. Insufficient benefit over existing formulary options.	x
Degarelix (Firmagon®)	Treatment of adult male patients with advanced hormone-dependent prostate cancer.	Non-*Formulary*.	x
Enoxaparin (Clexane®)	Acute ST-segment elevation myocardial infarction (STEMI).	(S) Total *Formulary*. Acknowledge new indication.	✓R
Etravirine (Intelence®)	Combination treatment of HIV-1 infection in adult patients.	(S) Total *Formulary*. Restricted to use by HIV specialists.	✓R
Fesoterodine fumarate (Toviaz®) (ADTC Appeal)	Symptomatic treatment of overactive bladder syndrome.	Non-*Formulary*. Inclusion of this medicine would be reconsidered following a future formal review of this entire section of the *Formulary*.	x
Infliximab (Remicade®)	Active ulcerative colitis.	Non-*Formulary* for this indication.	x
Omega-3-acid ethyl esters (Omacor®) (ADTC Appeal)	Secondary prevention following myocardial infarction.	Non-*Formulary* following consultation with the Cardiology MCN.	x
Peginterferon alfa-2a (Pegasys®)	In combination with ribavirin for the treatment of chronic hepatitis C in adults.	(S) Total *Formulary*. Acknowledge new indication.	✓R
Pegylated liposomal doxorubicin (Caelyx®)	In combination with bortezomib for the treatment of progressive multiple myeloma.	Non-*Formulary* for this indication.	x
Terlipressin acetate injection (Glypressin®)	Treatment of bleeding oesophageal varices.	(S) Total *Formulary*. Acknowledge new formulation.	✓R

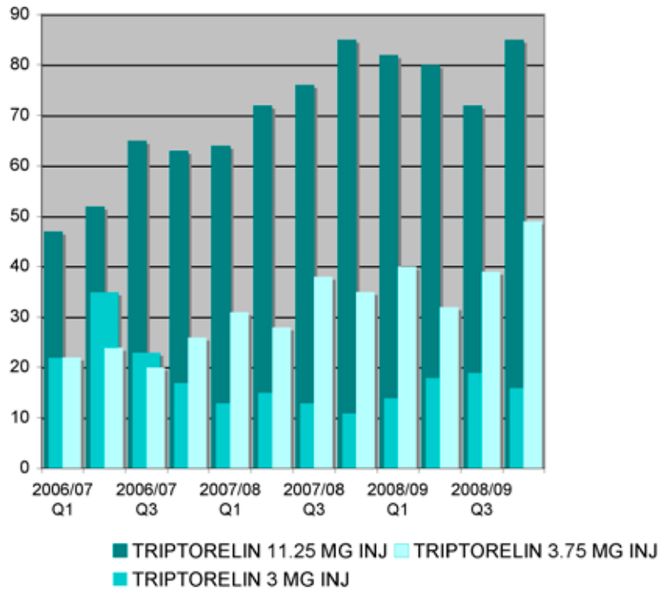
✓ =*Formulary* ✓R =*Formulary* (restricted) **x** =non-*Formulary* **?** = awaiting final decision (S) =specialist initiation only (S) =specialist use only

Gonadorelin analogues for metastatic prostate cancer

Postscript Extra no 14 'Triptorelin SR 11.25 mg in Metastatic Prostate Cancer' has been placed on the ADTC website. This supersedes *Postscript Extra* no 8 (June 2006). The advice remains the same; triptorelin is the preferred choice of gonadorelin analogue within NHSGGC for patients with metastatic prostate cancer.

The bulletin includes reasons why triptorelin is the preferred choice including information on efficacy, safety and method of administration. The bulletin has also been made available to oncologists to send to GPs when a patient is being initiated on this drug.

Primary care data shows significant increase in prescribing of this formulation; however the indication for use cannot be ascertained from the data.



Right: Primary care triptorelin prescribing

Reporting adverse drug reactions: Swine flu

A special web-based system for reporting adverse drug reactions (ADRs) to oseltamivir (Tamiflu®), zanamivir (Relenza®) and the H1N1 vaccines, when available, has been set up by the MHRA at **www.mhra.gov.uk/swineflu** *This will remain available for the duration of the pandemic and may be used by both healthcare professionals and patients.*

Before the current flu outbreak, use of antivirals in the UK was limited, with the public health policy for prevention of seasonal influenza infection focused on vaccination. It is possible that the wider prescribing of these medicines in a pandemic situation may reveal rare effects that have not previously been seen. Reporting ADRs is strongly encouraged to help monitor their safety.

The portal has been designed to make completing a report as quick and easy as possible. The following information should be included in any report:
- the patient's age,
- the indication (prophylaxis or treatment),
- information on any underlying risk factors for influenza complications or the ADR; or state if there are no known risk factors,
- any other information about the patient or additional clinical details which will help assessment of the case.

The existing Yellow Card Scheme will remain in operation for reporting suspected ADRs to all other medicines at **www.yellowcard.gov.uk**

Influenza A (H1N1) vaccination programme

Planning is now under way to deliver the influenza A (H1N1) vaccination programme to begin in the autumn, subject to the vaccine being licensed. The priority groups were confirmed on 13 August by the Scottish Health Secretary as:
- those aged between 6 months and 65 years in the current seasonal flu risk groups,
- pregnant women,
- household contacts of immunocompromised patients,
- those aged over 65 years in the current seasonal flu risk groups.

Frontline health and social care workers will be vaccinated at the same time as the first priority group. Maintenance of the cold chain and storage remain key issues, especially since the programme will be delivered alongside existing programmes (seasonal flu and childhood immunisation). The vaccine will be available as a 10 dose multidose vial and will be administered as two doses given 21 days apart.

Clinical guidelines on Staffnet

Work is underway to develop a central repository for all clinical information on the intranet. This can be accessed via the 'Clinical Info' button or by following the link to **staffnet/Clinical+Info/default.htm** Although content is limited at present, it includes:
- clinical guidelines, eg antibiotics, asthma, smoking cessation, treatment of depression in primary care,
- links to the *Formulary*, *Therapeutic Handbook* and referral information.

Scottish Patient Safety Programme: Medicines management

One of the five work streams within the Scottish Patient Safety Programme is 'medicines management'. The primary objective of this work stream is to reduce adverse drug events, through safe and effective medicines management processes. The current focus is on safer use of anticoagulants and improved medicines reconciliation processes. Frontline staff lead the work by making small tests of change designed to improve existing processes until they are shown to be more reliable, using appropriate process and outcome measures.

Anticoagulants

A 'Failure Modes and Effects Analysis' tool is used to evaluate the steps in the anticoagulant process for possible failures and the level of risk they would present. This assessment is done by the multidisciplinary team, with each profession offering a different perspective resulting in a more balanced assessment of overall risk. Risks are then prioritised from highest to lowest and systematically addressed through testing and implementing changes which lead to improvement. So far, sites have identified poor or incomplete patient information at discharge as their highest risk. A standardised educational checklist for ward nursing staff to use with patients has been successfully tested and implemented across several sites. The checklist includes: the yellow booklet, how to take the medicine, missed doses, side effects, interactions and monitoring arrangements following discharge.

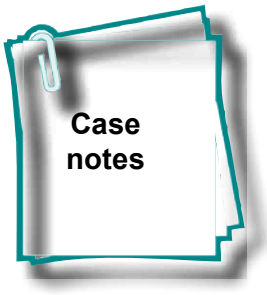
Medicines reconciliation

The purpose of medicines reconciliation is to ensure continuity of relevant medicines on admission to hospital and to reduce medication errors, particularly at the interfaces of care. Research has shown that poor communication at interfaces of care is responsible for up to 50% of all medication errors and up to 20% of adverse medication events in hospital. Medicines reconciliation involves collating a medication history, checking the accuracy of the information collected and communicating this information to all members of the healthcare team throughout the patient's journey to discharge.

The starting point for this process is admission to hospital. Pilot work within the CCU at RAH has tested a medicines reconciliation form which is completed within 24 hours of admission. The form supports clear documentation of the patient's medication upon admission, the source of this information, whether they have to be continued, changed or stopped and the reasons why. Testing on this site has shown an improvement in the proportion of patients having their medicines reconciled from 55% to 95%. Work is now under way to test the form within acute receiving wards at the GRI, SGH, RAH and VI. Access to the Emergency Care Summary, which is now happening across all sites, should support the medicines reconciliation process and will be looked at as part of the testing.

Copies of the anticoagulant discharge checklist and medicines reconciliation form can be found, along with more detailed information, in a resource pack at: **staffnet/Acute/Division+Wide+Services/Pharmacy+and+Prescribing+Support+Unit/Clinical+Governance/Scottish+Patient+Safety+Programme.htm**

Always counsel patients about common side effects



Patient A, who was suffering from increasingly problematic breathlessness, was referred to a consultant physician in respiratory medicine. He had presented with temporal arteritis three months before that and in that time had been on fairly high dose oral steroid.

On examination he had no evidence of lung disease with no airflow obstruction. Lung volumes were a little low, probably reflecting obesity. Over the three month period he had put on around four stones in weight with a classical Cushingoid distribution and substantial fat deposit around the upper airway in particular. The patient found himself very restricted in any activity and this had had a major impact on his quality of life. The weight gain and fat distribution was, in the opinion of the consultant, almost certainly the entire explanation for his breathlessness.

Weight gain on steroids is a well recognised side-effect: at least to some extent it is a matter of increased appetite and eating more. There are many situations in therapeutics where we pay very strict attention to potential drug side-effects. However this is one which is very common and where there may be a tendency to accept it as partly the price of continued steroid use. In this case, it was clear that the patient had not appreciated the potential problems of weight gain due to steroid therapy when the treatment was started. There had been no attempt to control the effect of increased appetite.

Learning points

- Patient on steroids should be maintained on the lowest effective dose for the minimum period possible.
- Consider obesity as a cause of developing or worsening breathlessness.
- Patients receiving long term steroids should be warned of the likelihood of increased appetite and weight gain.
- Patients should be counselled on healthy eating and given appropriate advice relative to their condition on maintaining or increasing physical activity.

Patient B presented to the Accident & Emergency Department after 24 hours of vomiting and diarrhoea. She was light-headed and had to be helped to walk. Clinical assessment revealed low blood pressure with a significant postural drop and deranged electrolytes consistent with corticosteroid deficiency. She had been taking prednisolone 5mg daily for over a year for joint pains. She was treated with intravenous hydrocortisone and fluids and recovered very quickly. The vomiting and diarrhoea settled after a further 24 hours in keeping with a norovirus infection.

Subsequent endocrine investigation (short Synacthen® test) confirmed a lack of adrenal cortisol secretion in response to appropriate stimulation. This patient had iatrogenic adrenal suppression from long term steroid use. Her presenting illness was acute adrenal insufficiency precipitated by minor infection and can be fatal if untreated. Patients on a maintenance dose of steroid should be taught to double their dose for three days during intercurrent illness or stress.

Learning points

- Patient on steroids should be maintained on the lowest effective dose for the minimum period possible.
- Adrenal suppression can result from long term exogenous steroid use.
- Patients must be warned about adrenal suppression and given written advice on how to increase their maintenance dose during intercurrent illness or stress.
- Patients known to have adrenal insufficiency can be trained to administer intramuscular hydrocortisone during a vomiting illness (through endocrinology service).

Vitamin B co-strong

ADTC has taken the decision to remove vitamin B co-strong tablets from the NHSGGC *Formulary* after a review of the available evidence. Historically, the primary use of this preparation was to address vitamin deficiency in patients with alcohol dependence and vitamin prophylaxis for Wernicke's encephalopathy. It is accepted that this preparation has little therapeutic benefit and a sub-therapeutic quantity of pyridoxine (vitamin B6).

The preferred step-down oral vitamin supplementation is thiamine (vitamin B1) 100mg three times daily. Vitamin B co-strong only contains 5mg of thiamine per tablet.

Over-the-Counter Codeine and Dihydrocodeine: New safety advice

New warnings and tighter controls on the sales of over-the-counter codeine or dihydrocodeine products are being introduced as the existing warnings of the risks of addiction and overuse headache have not proved effective. The indications will be restricted to short term (three days) treatment of acute, moderate pain which is not relieved by paracetamol, ibuprofen or aspirin alone. More detail will follow in *PostScript Primary Care*. See **www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/index.htm**

NHS Greater Glasgow and Clyde

Area Drug & Therapeutics Committee
Chair: Dr J Fox

Communications Sub-group
Chair: Mrs A Thompson

Published by the Communications Sub-group to reflect the views of the Area Drug & Therapeutics Committee but not necessarily those of NHS Greater Glasgow and Clyde.

PostScRipt

PostScript Editor: Mrs A Thompson
Prescribing Team, NHS Greater Glasgow & Clyde
Pharmacy & Prescribing Support Unit
Queen's Park House, Victoria Infirmary, Langside Road
Glasgow G42 9TY Tel: 0141 201 5214 Fax: 0141 201 5338
E-mail: audrey.thompson@nhs.net

PostScript Web editor: Dr A Power

Design, layout and production control:
Strathcashel Publications Project Management (01505 850 344)