PostScriptCommunity Pharmacy

NHS Greater Glasgow and Clyde

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Gabapentin and Pregabalin Potential for Misuse

Gabapentin and Pregabalin are licensed for the treatment of epilepsy and neuropathic pain. Pregabalin is also licensed for use in general anxiety disorder.

Recently there have been reports of the potential for misuse of these drugs in order to enhance mood level, to augment the effects of other drugs, to manage opiate withdrawals and cravings or to substitute other drugs such as cocaine. Gabapentin and pregabalin are structurally related to the neurotransmitter GABA and it is this common role for GABA-related effects which is believed to cause the potential for these drugs to be misused by patients.

Although some studies focus on people misusing gabapentin with a history of cocaine dependence, anecdotal reports from certain Health Boards across Scotland have highlighted gabapentin misuse by opiate users. While the current evidence around gabapentin and pregabalin misuse is limited, both pharmacists and prescribers should be aware of the potential for misuse of these drugs and be cautious when prescribing either drug, particularly to individuals with a known history of substance misuse.

Supervised Methadone: Take care with patient identification

The CD Team has received a number of reports recently where patients have been given the wrong dose of methadone, usually due to mistaken identity. We had flagged this as an issue in the September 2010 bulletin, but reports are still being received.

It is vital that appropriate checks of identity are carried out every time a patient presents for their supply.

- The patient should provide the details rather than confirm what you tell them. Ask them for their name and date of birth; don't ask if they are Joe Bloggs.
- Ask the patient to confirm the expected dose; this acts as another check.

If you do discover that you have given a patient an incorrect dose, you must take immediate action to inform the patient and the prescriber and ensure the patient does not come to harm.

Extemporaneous Methadone From the Controlled Drug Governance Team

"I would recommend that no pharmacist uses it".

"Just talking about it on the phone is making me feel anxious".

Two comments from an experienced community pharmacist in NHSGGC recently when they recalled an incident involving extemporaneous methadone.

The incident occurred when a member of the pharmacy staff made up a litre of sugar free methadone, not with the 1g jar designated for this purpose but instead with a jar containing 5g of powder. The resultant solution was five times the strength required.

By chance the pharmacist noticed the error, but not until extra 1mg/ml solution had been added to the container. By luck none was dispensed.

Efforts to rectify the matter were complicated by not being able to obtain enough sugar free green syrup alone, without the methadone powder to accompany it. The over-strength methadone solution remained in the cupboard for a number of days until the pharmacist decided to dispose of it.

The pharmacy did have robust SOPs in place and did maintain accurate records and an extemporaneous log.

The pharmacy staff are well trained, capable and conscientious

"I totally panicked"

"I asked my dispenser to witness me destroying it"

Extemporaneous methadone is an unlicensed product and should only be supplied in exceptional circumstances. Increased risk is inherent in the manufacturing process and all supplies should be brought to the attention of the prescriber and the client by the pharmacist. Disposal of methadone stock is illegal unless carried out in the presence of the Authorised Witness.

Produced by: Community Pharmacy Development, Queens Park House, Victoria Infirmary, Langside Road, G42 9TT Tel. 0141 201 5427 GG-UHB.cpdevteam@nhs.net

APC December Meeting Update – Safe and Secure Handling of Medicines in Primary Care.

The December meeting of the APC heard a presentation from Colette Byrne (lead pharmacist, Medicines Governance) on Safe and Secure Handling of Medicines within Primary Care environments.

In April 2008 a policy on Safe and Secure Handling of Medicines within Acute settings was ratified and implemented across all Acute sites. Since then, work has been ongoing to develop a complementary Primary Care based document. After Board-wide consultation the Primary Care version is soon to be ratified and will be ready for implementation in the first part of 2012. This is a policy document for all NHS GGC employees working in primary care and is recommended as key guidance for independent contractors.

The main aims of the policy are to

- ensure NHS GGC complies with all relevant legislation in relation to the safety and security of medicines
- promote review and adoption of best practice in relation to the safety and security of medicines manage the risks to both patients and staff that arise from the handling of medicines

The main section in the document describes the "system" that ensures safety and security in handling medicines in healthcare service areas, with specific recommendations on -

- Responsibility
- Procedures
- Ordering
- Receipt and records
- Storage
- Security
- Prescribing and administration of medicines
- Return and disposal of medicines

Smaller sections also include guidance on the specific areas of transport and posting of medicines, Out of Hours supplies and clinical incidents

This document is applicable to all staff who handle / order / supply / prescribe medicines in any way in the course of their business, so includes a very diverse range of practitioners (e.g. District Nurses, Prescribing Support Pharmacists, GPs, Dentists, Community Pharmacists). It is intended to be used as a reference document, with the launch prompting some reflection and review of process and procedures currently used. The vast majority of the document is not "new" but is a description of current ongoing good practice.

Any comments or queries on the Primary Care or Acute Safe and Secure Handling of Medicines polices should be directed to the dedicated e-mail address – sshm@ggc.scot.nhs.uk

Change to reporting of HbA1c

On 16th January 2012, the way in which HbA1c results are reported will change. Glucose in the blood binds irreversibly to a specific part of haemoglobin in red blood cells, forming HbA1c. The higher the glucose is, the higher the formation of HbA1c. HbA1c circulates for the lifespan of the red blood cell, so reflects the prevailing blood glucose levels over the preceding 2–3 months. Two large studies have indicated that the risk of microvascular and macrovascular complications of diabetes increases as HbA1c increases. HbA1c thus gives a measure of an individual's risk of the long-term complications of diabetes.

The units for reporting HbA1c will change from a % score to a mmol/mol reading. The table below is a guide to how old and new values relate over a wider range.

DCCT HbA1c (%)	IFCC HbA1c (mmol/mol)
4.0	20
6.0	42
6.5	48
7.0	53
7.5	59
8.0	64
9.0	75
10.0	86
12.0	108
14.0	130
16.0	151

According to SIGN 116, glycaemic control targets for patients with type 1 diabetes should be 6.5-7.5% (48-58 mmol/mol) but with an aim to achieving as close to normal glycaemic control levels as possible. Type 2 patients should aim for 6.4% (46 mmol/mol) to 8.0% (64 mmol/ mol) to reduce potential for microvascular and macrovascular complications.

Community pharmacists are asked to note these changes. Further information can be obtained from the Diabetes UK website

(http://www.diabetes.org.uk/Guide-to-diabetes/Monitoring/Blood_glucose Glycated_haemoglobin_HbA1c_and_fructosamine)

which is also a very good resource for patients. Pharmacists can help support patients during this transition change by helping them to understand the implications of the new numbers which could also potentially be recorded as a care issue for CMS registered patients.