Prescribing Points

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Oxfordshire Cinical Commissioning Group

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This newsletter is for all health professionals in Oxfordshire and is written by the Medicines Management Team, Oxfordshire CCG, Jubilee House, Oxford Business Park South, Oxford, OX4 2LH

Primary Care Prescriber Decision Support for New Oral Anti-Coagulants (NOACs)

New guidance is now available on the CCG intranet: *Primary Care Prescriber Decision Support for the NOACs for Long Term Thromboprophylaxis in Atrial Fibrillation.* It aims to provide a stepwise approach to help in the decision making process when choosing an oral anticoagulant in AF in line the recent NICE guidance. Aspirin is no longer recommended as an option. It summarises differences between warfarin and the NOACs (see table below), highlights safety data including a summary of clinical trial data and gives a comparison of the different NOACs available. Please see main guideline for full details.

Warfarin	NOACs
Has been prescribed for more than 50 years	Compared to warfarin NOACs are relatively new to market
Effective antidote with prothrombin complex concentrate (PCC) and vitamin K should a severe bleed occur. Vitamin K takes hours to have an effect.	No licensed antidote. Reduced risk of intracranial haemorrhage
Time to full anticoagulation can be a week or more.	Immediate effect (peak 1-4 hours)
Patient needs regular follow up and blood sampling	Useful for patients who have difficulty getting INR measured. Minimum of U&E and LFT annually.
Cannot be put in a dosette box unless risk assessment has been done and a management plan is in place to manage dose adjustment	Rivaroxaban and apixaban are stable in a dosette box and so useful for patients who need external support to take medicines
For patients with ACS or stents in last 12 months follow Cardiology advice regarding use of antiplatelets. Aspirin can be stopped if chronic IHD >12 months from event/intervention	For patients with IHD ACS or stents follow Cardiology advice regarding use of antiplatelets
Correct INR can be difficult to manage despite good compliance	Useful for patients with erratic INR not due to non-compliance
Warfarin and coagulation factors have long half-lives therefore missed doses result in less loss of anticoagulation compared to NOACs	NOAC have short half-life and so missed dose have greater loss of anticoagulation than warfarin

So what?
Prescribers should be aware of the updated NICE AF guidance and when to initiate an anticoagulant. The local guidance should help when making a decision about which anticoagulant to use for individual patients

European Antibiotic Awareness Day

The 18th November is European Antibiotic Awareness day. In support of this, Public Health England have launched the 'Antibiotic Guardian' campaign which is asking everyone in the UK, the public and clinical community, to become Antibiotic Guardians by making a pledge that they personally will take to conserve our antibiotics and to ensure that they are effective when we really need them.

The English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) have recently published their first report which highlights an increase in the use of antibiotics linked to rising levels of antibiotic resistance in the UK. This also reported the variability in prescribing levels around the country. The highest combined general practice and hospital usage was in Merseyside [30.4 DDD per 1,000 inhabitants per day], where levels of use were similar to those reported from Southern Europe, and over 30% higher than in the Thames Valley, which had the lowest usage [2.8 DDD per 1,000 inhabitants per day]. The highest prescribing from general practice was in Durham, Darlington and Tees, which was over 40% higher than in London.

- Antibiotic Guardian pledges can be made at http://antibioticguardian.com/
- Further resources including posters, patient leaflets and quizes can be found at: https://www.gov.uk/government/collections/european-antibiotic-awareness-day-resources
- Particularly useful is the 'treating your infection' leaflet available from the Royal College of GPs as part of the TARGET antibiotics toolkit. This includes information on illness duration, self-care advice and advice on when to re-consult. It can be personalised for the individual patient and is available in a number of different languages. This leaflet is also available via DXS.

So what?
Healthcare professionals are asked to continue to support the national campaign and use the material available to promote this message to the public. Encouragingly, ESPAUR report shows that Thames Valley has the lowest practice and hospital usage of antibiotics in the country.

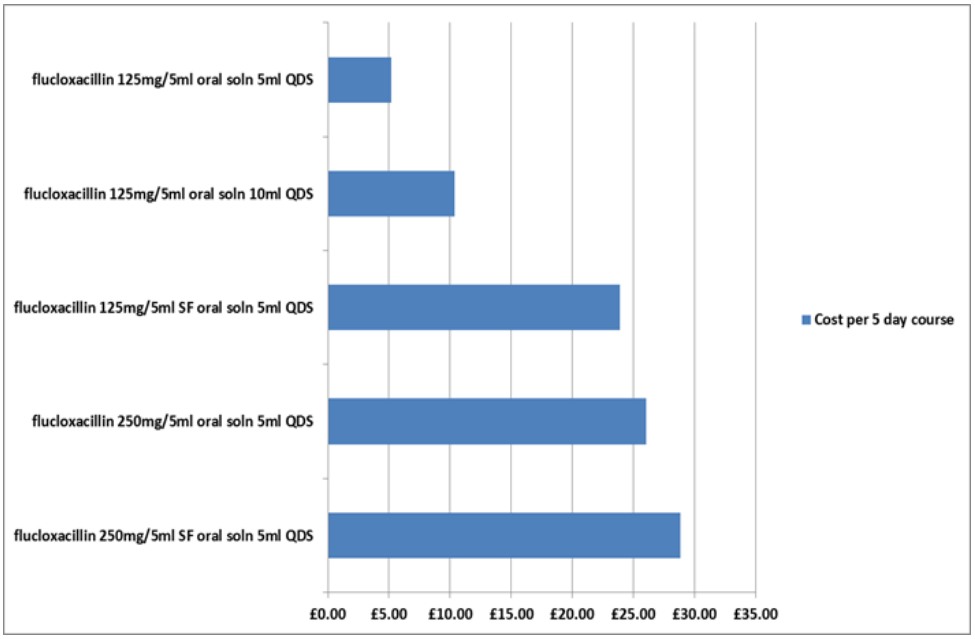
Flucloxacillin liquid

Flucloxacillin 125mg/5ml oral solution has reduced in price over the last few months. It is currently £5.19 per 100ml making it £19 cheaper than the sugar-free equivalent strength (£23.87).

A Scriptswitch message is already available alerting prescribers to this cost saving.

The price of the 250mg/5ml oral solution remains £26.04 but this is nearly £3 cheaper than the sugar-free equivalent strength (£28.87).

Alternatively, a double dose of 125mg/5ml oral solution could be used which is a more cost effective option.



So What?
Ensure the most cost effective formulation of flucloxacillin liquid is prescribed – currently flucloxacillin 125mg/5ml oral solution

Prescribing Reminders

Denosumab is now part of the Primary Care Pathway for Osteoporosis and MHRA update
As highlighted in the August edition of Prescribing Points, GPs in Oxfordshire can now initiate denosumab in patients that meet the criteria in the guideline.

Denosumab can be used third line, following alendronate and risedronate, for patients who meet the criteria. The first dose can now be given in primary care and funding from secondary care has been moved to support this change. Funding for all doses given will be through the near patient testing specification. This change will benefit high risk patients who will no longer have to travel to hospital to receive their first injection.

MHRA update: Clinicians should monitor calcium levels prior to each dose of denosumab and within two weeks after the initial dose in patients predisposed to hypocalcaemia. Patients should be advised to report to their clinician symptoms of hypocalcaemia such as paraesthesia or muscle stiffness, twitching, spasms or cramps. Dental examination is advised and patients should report any dental symptoms such as dental mobility to minimise the risk of osteonecrosis of the jaw.

Insulin degludec (Tresiba) is Consultant Initiation Only
Degludec is a long acting human insulin analogue for once daily administration by sub cutaneous administration. Please note that it is to be **only** started on the recommendation of a consultant. The guideline can be accessed here.

Metoject® syringe – replaced by Metoject® PEN

1. The current **Metoject® syringe** has changed to a **Metoject® PEN.** Metoject® syringe will be discontinued.
2. **Metoject® PEN** is a licensed, pre-filled methotrexate single use auto-injector.
3. Methotrexate Injection should be prescribed ***ONCE WEEKLY*** as either :
    - **Metoject® PEN** or generically as
    - **Methotrexate solution for injection pre-filled disposable device**

Please ensure that:

- Your computer system has been updated to include Metoject® PEN and the generic Methotrexate solution for injection pre-filled disposable device
- Repeat prescriptions have been altered to Metoject® PEN or the generic equivalent
- Patients are aware of the change of administration required with the new device. The Metoject website has some useful information including a video and a patient information leaflet and some FAQs.

Metoject® PEN characteristics	**Metoject® PEN safety points**
Single use & easy to handle. One button activation	Do not try to remove the air bubble in the **Metoject® PEN**
Concentration 50mg/ml	Inject at a 90° angle
Available in doses: 7.5mg, 10mg, 12.5mg, 15mg, 17.5mg, 20mg, 22.5mg, 25mg, 27.5mg 30mg, and in single and multiple pack sizes	Rotate weekly injection sites to minimise possibility of skin reactions
Room temperature storage	Automatic needle shield protection to prevent the possibility of needle stick injury
24 months shelf life from date of manufacture	Colour coded for easy dosage identification
Preservative and latex free	

Product characteristics and prescribing information can be found at http://www.medicines.org.uk/emc/medicine/28982

Sorbion S Extra Project Update.

In May this year, we launched the Sorbion project, using Sorbion S Extra as our first line super absorbent for wounds that are moderate to highly exuding. This launch was supported by a number of clinical workshops and by an exudate pathway.

The aim of the project is to demonstrate better outcomes that include: improved healing rates, reduced local wound bed infection; improved peri -wound skin, reduced nursing contacts (nursing capacity) and reduced spend. To achieve this, the patient requires a holistic assessment to help identify the barriers to healing and Sorbion needs to be used correctly.

We have already had some really encouraging clinical results following the introduction of the exudate pathway but following the anticipated initial peak, spend has remained relatively high. Usage/ spend is monitored closely by medicines management and currently tissue viability is contacting high users to offer advice and support re their wound management plans. As a result of this communication there are key themes that need clarifying:

- **Sorbion S Extra is a step up product**. Zetuvit should be a first line consideration and should be used to manage low to moderately exuding wounds. If found to be ineffective i.e. not managing exudate levels, peri -skin is becoming macerated, you are having to increase dressing changes, then you should step up to Sorbion S Extra. (Zetuvit pads are encased wadding so if exudate is too much it runs the risk of macerating the periwound skin as it has no ability to lock in the moisture). Sorbion S Extra should be 'swollen' with wound exudate when you come to change it, if this is not the case either leave on longer or step down to a Zetuvit E pad.
- **Leave On Longer** – Sorbion is not always being left on for long enough. It can be left on for **four** days and can be used as a primary dressing. If the dressing is sticking to the wound bed you should consider using an Atrauman, but in many incidences if you just leave the dressing on longer it will resolve this problem.
- **Incorrect Size selection** - The correct sizing should be considered before application. You only need a 3cm border around wound edges. Do not apply a 30 x 20 pad or an XL unless the patient has a circumferential wound. Pads do not need taping, hold the pad in place with a couple of wraps of K soft wool.
  N.B. If you have a patient with large leaky, circumferential leg ulcers, Sorbion XL is more efficient and cost effective than two 20x20cm sized dressings.
- **Layering** – Sorbion S Extra should not be layered as it does **not** allow the transfer of fluid through the top of the dressing. Once the pad is full it should be changed.

Summary of Guidance for Sorbion Sachet EXTRA

-DO leave on for FOUR days
-DO use on moderate to highly exuding wounds
-DO choose an appropriate dressing size leaving a small dressing margin around the wound
-DO apply directly to the wound bed as a primary dressing
-DO use a fixation product to secure
-DO use in place of alginates, hydrofibres and other absorbant dressings
-DO use under compression and area of pressure
-DO use on infected wounds as a complementary treatment regime as bacteria are drawn into the dressing core
-DO NOT use with multiple dressings i.e. do not layer
-DO NOT cut/fold
-DO NOT use in contact with mucous membranes or dry wounds
-DO NOT use on thick black necrosis nor on bleeding wounds

So What?

Clinicians are encouraged to follow the exudate management Pathway but if you are struggling to manage a patient's exudate please contact Tissue Viability via email or refer your patient to Tissue viability and they will be happy to support you. oxfordhealth.tissueviability@nhs.net or tissueviability@oxfordhealth.nhs.uk