Kent and Medway Medicines Optimisation Team

Prescribing and Medicines Management –

COVID-19 Weekly Newsletter

NHS Kent and Medway Clinical Commissioning Group

Issue (4) 8th of April 2020

Welcome to the **COVID-19** K&M Medicines Optimisation (MO) news update.
Articles in this week's edition include:

- MHRA Statement on Chloroquine and Hydroxychloroquine
- MHRA: COVID-19 and Antihypertensive Medication
- COVID-19 Rapid Guideline: Managing Suspected or Confirmed Pneumonia in Adults in the Community
- Guidance on Contraceptive prescribing during COVID-19
- Management of Patients Requiring Anticoagulation
- Easter opening for Community Pharmacy
- Other NICE COVID-19 Rapid Guidelines

Please send all medicines queries relating to COVID-19 to:
wkccg.gpscovid19@nhs.net

MHRA Statement on Chloroquine and Hydroxychloroquine

The MHRA has issued a reminder to UK clinicians that Chloroquine and Hydroxychloroquine are not licensed to treat COVID-19 related symptoms or prevent infection. Clinical trials are ongoing to test chloroquine and hydroxychloroquine as an agent in the treatment of COVID-19 or to prevent COVID-19 infection. These clinical trials are still not completed, so no conclusions have been reached on the safety and effectiveness of this medicine to treat or prevent COVID-19. Until there is clear, definitive evidence that these treatments are safe and effective for the treatment of COVID-19, they should only be used for this purpose within a clinical trial. Access source (here)

MHRA: COVID-19 and Antihypertensive Medication

The MHRA has mirrored the advice from the European Society of Cardiology stating that there is no evidence from clinical or epidemiological studies that treatment with ACE-I or ARBs might worsen COVID-19 infection. More information available (here)

COVID-19 Rapid Guideline: Managing Suspected or Confirmed Pneumonia in Adults in the Community

COVID-19 pneumonia is caused by a virus therefore antibiotics are ineffective. It is recommended not to offer antibiotics for treatment or prevention of pneumonia if:

- COVID-19 is likely to be the cause and
- Symptoms are mild.

Inappropriate antibiotic use may reduce stock availability if used indiscriminately, and broad-spectrum antibiotics in particular may lead to *Clostridium difficile infection* and antimicrobial resistance.

Antibiotic Treatment

Offer an oral antibiotic for treatment of pneumonia in people who can or wish to be treated in the community if:

1. The likely cause is bacterial.
2. It is unclear whether the cause is bacterial or viral and symptoms are more concerning.
3. If patients are at high risk of complications because, for example, they are older or frail, or have a pre-existing comorbidity such as immunosuppression or significant heart or lung disease (for example bronchiectasis or COPD), or have a history of severe illness following previous lung infection.

First choice of antibiotics: doxycycline 200 mg on the first day, then 100 mg once a day for 5 days in total (not in pregnancy). **Alternative:** amoxicillin 500 mg 3 times a day for 5 days. See NICE COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community for more information.

Oral corticosteroids

NICE recommends that oral corticosteroids should not routinely be offered to patients with pneumonia unless the patient has other conditions for which oral corticosteroids are indicated, such as asthma or COPD.

FSRH Clinical Advice to Support Provision of Effective Contraception during the COVID-19 Outbreak

The Faculty of Sexual & Reproductive Healthcare (FSRH) has produced guidance to help primary care clinicians support women with their contraceptive needs during the coronavirus pandemic. The guidance covers hormonal contraception including; POP, CHC, Depo Provera, IUD, IUS, implants, new contraception starters and emergency contraception. Access the full guidelines (here)

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Management of Patients Requiring Anticoagulation

NHS England has issued guidance for patients requiring initiation of oral anticoagulation. Patients with mechanical heart valves should be initiated on warfarin. However, when monitoring is not possible, then a brief period of low molecular weight heparin (LMWH) could be considered if the patient can be taught to self-inject or a family member living with them can administer the injection. For other patients in whom DOACs are not an option, consider a LMWH if the patient can be taught to self-inject or a family member living with them can administer the injection. ***In view of recognised supply issues with LMWH, these should only be used if there are no other appropriate options.***

If a patient must have warfarin, consider whether they or a family member living with them can be taught to self-test their INR using a CoaguChek machine (providing this can be secured), and then phone in the results for dose adjustment.

To protect the supply chain for all patients, switches from warfarin to DOACs, should take a phased approach over the 12-week cycle of INR monitoring. ***Consider prioritising patients with poor control of INR as this cohort will need the most frequent INR checks.*** Address non-adherence if this an underlying reason for poor INR control.

All DOACs are licensed for the prevention of:

- atrial fibrillation (AF)-related stroke in people with non-valvular AF
- treatment and secondary prevention of DVT/PE
- prevention of DVT/PE post-hip and knee surgery.

Low-dose rivaroxaban is also licensed for:

- acute coronary syndrome
- stable coronary artery disease
- symptomatic peripheral arterial disease

As a last resort, for individual patients for whom INR testing is not possible and therefore warfarin cannot be dosed safely **and** DOACs and LMWH are not suitable, warfarin therapy could be temporarily stopped after weighing the benefit and risk and discussion with the patient. Regular review should be undertaken with a view to restarting warfarin therapy as soon as it is safe to do so.

In line with NICE guidance, where more than one product is available for the indication, the product with the lowest acquisition cost should be used. More information available (here)

Community Pharmacies Easter Opening

NHS England and NHS Improvement (NHSE&I) have announced that where possible, community pharmacies will be open from 2pm-5pm on Good Friday and Easter Monday. Some pharmacies may be open longer than this but this is the minimum time they will be open. Easter Saturday hours will be normal COVID-19 opening hours and the Easter rota for Easter Sunday still stands for community pharmacy.

Latest NICE COVID-19 Rapid Guidelines

In response to COVID-19 the National Institute of Clinical Excellence (NICE) is producing rapid guidelines to support clinicians manage specific patient groups. The latest guidelines produced are listed and linked below:

- Rheumatological autoimmune, inflammatory and metabolic bone disorders (NG167)
- Severe asthma (NG166)
- Managing suspected or confirmed pneumonia in adults in the community (NG165)
- Managing symptoms (including at the end of life) in the community (NG163)