NHS
Kent and Medway

Medicines Optimisation updates – [May 2023 issue 46]

New Back-up (delayed) Antibiotic Prescribing Guidance

NICE antimicrobial guidance includes a ‘back-up’ prescription as an option in acute sore throat (in addition to otitis media, cough, and sinusitis.)

Practices participating in the 2022-2024 MOS are likely to have completed their audit for antibiotic prescribing for sore throat in children, and following this audit

may be planning to build the use of delayed/back-up prescribing into their practice improvement plans.

To support with this, Kent and Medway back-up prescribing guidance has now been approved. This can be found on your local formulary website and includes information on:

•The benefits and when it may be appropriate

•Considerations for infants and children

•The six methods of producing a back-up prescription, their pros and cons

•A six-step process for post-dating EPS prescriptions

•Counselling and safety netting checklist

•Patient information leaflet

New *C. difficile* Prescribing Guidance and Access Information

NICE guidance for the treatment of *Clostridioides difficile* infection (CDI) currently recommends oral vancomycin as first-line for the first episode of mild, moderate or severe cases with fidaxomicin as the second line option where vancomycin is ineffective. Metronidazole is no longer recommended for the treatment of *C. difficile*.

Community pharmacies do not routinely hold stock of vancomycin capsules and fidaxomicin tablets or granules and will likely need to obtain stock from wholesalers. Most pharmacies will receive twice daily delivery from wholesalers during weekdays and on Saturday morning so stock can be obtained on the same day.

However, for situations where this is not possible, for example weekends, bank holidays or out of hours, and in cases of clinical urgency in primary care where there is a need to start treatment immediately, 8 pharmacies have been commissioned to hold enough stock of vancomycin and fidaxomicin to cover one course of treatment. (Two in each HCP.)

Guidance has now been approved which supports patients and prescribers to access treatment for CDI in primary care at these 8 pharmacies. This guidance includes the locations, contact details and opening hours of these eight pharmacies to support teams in directing patients to their closest pharmacy and is available on your local formulary website.

Although 8 pharmacies have been commissioned, the final pharmacy in East Kent is currently being finalised and following confirmation of this the document will be updated accordingly.

Please note that as per NICE guidance, all suspected or confirmed C. difficile cases should be discussed with a Microbiologist prior to initiating treatment, and before moving from first-line to second-line therapy.

Hormone Replacement Therapy (HRT) Prescribing Guidelines

In April 2023, HRT prescribing guidelines were approved at IMOC (Integrated Medicines Optimisation Committee) for use across Kent & Medway (for both primary and secondary care).

The guidelines include a position statement on the off-label use of testosterone, under “Testosterone”, as well as other guidance which may be useful such as information about managing HRT shortages, prescription charges and durations, private prescriptions, bioidentical hormones, and patient information/resources.

Please find the approved guidelines link below, which can now be used and shared. The guidelines will be uploaded to all formulary websites in due course.
km-hrt-prescribing-guide.pdf (medwayswaleformulary.co.uk)

Along with the guidelines being approved, the formularies were reviewed and have been aligned across Kent & Medway for HRT. The agreed formulary is within the guidelines, under “Formulary Treatment Options”. The formulary websites will also be updated in due course to reflect this.

Sharing Learning from a Serious Incident

A serious incident has been reported to NHS Kent and Medway whereby a patient’s dose of Atomoxetine was increased from 10mg to 80mg in error.

The patient’s specialist agreed an increase in the patients Atomoxetine from 10mg to 18mg. A verbal medication review report was completed to communicate the change to the patients GP. This was sent to an external dictation company who transcribed the report, writing 80mg. The report was checked and sent to the patients GP who amended the repeat prescription in line with the request.

Atomoxetine 80mg was issued, dispensed and supplied. The patient started taking this dose and became lethargic, nauseous, tachycardic and had difficulty swallowing tablets.

Organisations are asked to consider:

1. Using dictation software that transcribes voice to text

2. The written information provided to patient and families around medication change, side effects and direct contact details for immediate support if required.

3. The use of medication templates where clinical systems will allow to review dictation element of medication transcription.

4. How changes to repeat medications are checked and approved.

Potential under-recognised risk of harm from the use of propranolol in certain patient cohorts

In February 2020 the Healthcare Safety Investigation Branch (HSIB) undertook an investigation into the under-recognised toxicity of propranolol in overdose following the unfortunate death of a patient from an overdose of propranolol.

As a reminder, the medicines optimisation team wishes to highlight to clinicians the potential under-recognised risk of propranolol toxicity in overdose, and the increased risk in patients with co-existing migraine, depression, or anxiety who are taking antidepressants, who may use propranolol for self-harm.

Further information on the national investigation and safety recommendations are included in the full report which is available here.

MHRA Drug Safety Update – April 2023

The latest MHRA Drug Safety Updates can be accessed at Drug Safety Update - GOV.UK (www.gov.uk) . This includes links to alerts, recalls and safety information and to the monthly Drug Safety Update PDF newsletter.

The April 2023 Drug Safety Update includes:
Nitrofurantoin: reminder of the risks of pulmonary and hepatic adverse drug reactions - GOV.UK (www.gov.uk)
Advice for healthcare professionals:

- advise patients and caregivers to be vigilant for new or worsening respiratory symptoms while taking nitrofurantoin and promptly investigate any symptoms that may indicate a pulmonary adverse reaction
- pulmonary reactions may occur with short- or long-term use of nitrofurantoin, and increased vigilance for acute pulmonary reactions is required in the first week of treatment

- patients receiving long-term therapy, for example for recurrent urinary tract infections, should be closely monitored for new or worsening respiratory symptoms, especially if elderly
- immediately discontinue nitrofurantoin if new or worsening symptoms of pulmonary damage occur
- be vigilant for symptoms and signs of liver dysfunction in patients taking nitrofurantoin for any duration, but particularly with long-term use, and monitor patients periodically for signs of hepatitis and for changes in biochemical tests that would indicate hepatitis or liver injury
- use caution when prescribing nitrofurantoin in patients with pulmonary disease or hepatic dysfunction, which may mask the signs and symptoms of adverse reactions
- advise patients to read carefully the advice in the Patient Information Leaflet about symptoms of possible pulmonary and hepatic reactions and to seek medical advice if they experience these symptoms
- report suspected adverse drug reactions (ADRs) to the Yellow Card scheme

Isotretinoin (Roaccutane▼): new safety measures to be introduced in the coming months, including additional oversight on initiation of treatment for patients under 18 years - GOV.UK (www.gov.uk)

- The Isotretinoin Expert Working Group of the Commission on Human Medicines has made recommendations to strengthen the safety of isotretinoin treatment. Recommendations include new warnings, the need for consistent monitoring requirements for psychiatric side effects, the introduction of new monitoring requirements for sexual side effects, and additional oversight of the initiation of treatment for patients younger than 18 years.

- While processes to support the implementation of these recommendations across the healthcare system are being developed, prescribers of isotretinoin are reminded of the need to fully inform all patients of the potential benefits and risks associated with isotretinoin treatment and monitor patients closely for any side effects throughout treatment.

Janus kinase (JAK) inhibitors: new measures to reduce risks of major cardiovascular events, malignancy, venous thromboembolism, serious infections and increased mortality - GOV.UK (www.gov.uk)

Letters and medicine recalls sent to healthcare professionals in March 2023 - GOV.UK (www.gov.uk)

Please follow the link in the titles above for more information and resources.
The MHRA Central Alerting System alerts can be accessed at https://www.cas.mhra.gov.uk/Home.aspx **.**

The MHRA released a safety alert on 9th May 2023 to advise patients, carers and their GPs, that anyone who uses Emerade® adrenaline pens (300mcg or 500mcg strengths) for anaphylaxis, should return to their GP to be prescribed an alternative product. This is precautionary guidance, as some pens have failed to activate, and therefore may fail if required in an emergency.
Patients asked to return Emerade 300 and 500 microgram adrenaline pens for replacement - GOV.UK (www.gov.uk)
A letter has been developed that can be sent to patients once identified by the GP practice.

Letter - Advice for patients who have been prescribed an Emerade auto-injectors.pdf

GP practices will need to identify any patients who have had Emerade® in the last 30 months (which is the shelf-life of the Emerade® pen, although many will have much shorter expiry dates). These patients can be contacted, using the template letter if suitable, and the practice will need to issue a prescription for 2 alternative pens:

- Emerade ®300mcg- Issue 2 x Jext® 300mcg OR 2x Epipen® 0.3mg pens
- Emerade® 500mcg- Issue 2x Jext® 300mcg OR 2x Epipen® 0.3mg pens

Once the patient has collected their new pens from the pharmacy, they may dispose of the Emerade® devices. Please ensure all patients have sufficient training on how to use their new devices, face to face if possible, but as a minimum providing the following patient information leaflets.

JEXT (medicines.org.uk) and pil.4289.pdf (medicines.org.uk) (Epipen)

AQUACEL Ag+ Upgrade

Aquacel® Ag has been replaced by Aquacel® Ag+ Dressings

Older versions of Aquacel® Ag have been discontinued. Please order **Aquacel® Ag+ extra** as the replacement.

We are aware that the name change has caused confusion within some practices as not all EMIS systems have been updated to reflect the name change which has led to some potential prescribing of unpreferred and sometimes more expensive products. Please order Aquacel Ag+ extra as the replacement.

For more information please refer to wound.webcare@convatec.com or 0800 289 738

Shortages Summary May 2023

Please find the medicines shortages update (up until 11th April 2023) link. Practices are encouraged to register for access to the SPS website https://www.sps.nhs.uk/ and access the full medicines supply tool directly in real time.

shortage-summary-issue-46-may-23.pdf (medwayswaleformulary.co.uk)