Drug News

NHS Plymouth

The newsletter for General Practitioners, Nurse Prescribers and Community Pharmacists within NHS Plymouth

Issue 70 March 2011

Please review all methotrexate prescriptions

There continues to be serious incidents involving methotrexate.

A recent Pharmaceutical Journal article (Feb 2011) described the events leading to the death of a patient suffering from a number of co-morbidities including inflammatory arthritis. The patient was prescribed a weekly increasing dose of methotrexate by hospital doctors intended to reach a regular dose of 25mg per week. He was given a methotrexate monitoring book and printed guidelines.

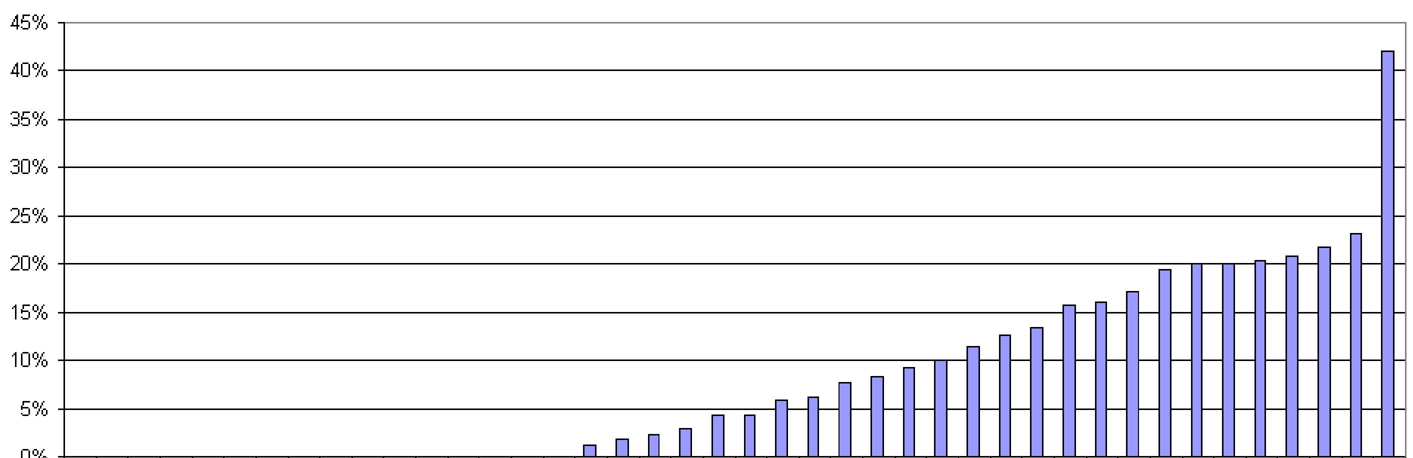
This did not go as intended and the patient continued to increase his methotrexate dose by one tablet each week for a further five months far exceeding the intended maximum dose. Sadly the patient died as a consequence. The coroner's report said "Despite the protocol and clear guidelines it does not seem that anyone at the surgery ever examined the monitoring book when repeat prescriptions were issued, and at the pharmacy on rare occasions only and certainly not between 20 July and 16 October 2009". The issue was only revealed when the patient's wife spoke to the community pharmacist while collecting a repeat prescription shortly before his death.

The report advises that methotrexate monitoring protocols need to be distributed and impressed upon all clinicians, GPs and pharmacists. Full guidance on the prescribing of methotrexate can be found in the new online PAJF (http://www.plymouthformulary.nhs.uk/Shared-care-information-on-the-prescribing-of-oral-Methotrexate/).

We have been monitoring the prescribing of methotrexate 2.5mg tablets through ePACT since the National Patient Safety Agency Alert (NPSA) in 2004. The quantities that are being prescribed still seem to be quite high considering this drug is usually taken once a week. The most recent ePACT data show that in the past 6 months there were 189 prescriptions for 56 or more methotrexate 2.5mg tablets. This includes prescriptions written for 336, 224 and 120 tablets! If prescriptions are for a small amount it is more likely to prompt and remind patients they are to be taken weekly not daily.

Attached is a graph showing the percentage of methotrexate prescriptions at each surgery for quantities of more than 56 tablets. For only a very few patients (taking high doses) would larger quantities be appropriate. Please ensure that the quantities you are prescribing are suitable for once weekly dose rather than daily dose and reduce if necessary. For patients on a fixed dose, check and confirm the number of tablets prescribed on the last prescription cover the period over which they were taken when they request the next repeat to help identify any issues like that described above.

Also please ensure that you have full and complete instructions on the prescriptions i.e. Methotrexate 2.5mg, (quantity of tablets to be taken as a single dose) ONCE A WEEK on XXXDAY.



Plymouth Area Joint Formulary (PAJF) website: **www.plymouthformulary.nhs.uk** To assist in promoting safe, cost-effective prescribing in both primary and secondary care within the Plymouth Health Community.

THE MEDICINES MANAGEMENT TEAM,
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Tel: 01752 434870 Fax: 01752 315710

Fentanyl patch concerns - part 2

As the second part of our series on fentanyl patches we have chosen to cover when it is appropriate to use fentanyl patches.

Fentanyl patches have been available for over fifteen years since the original Durogesic® patches were launched for "the management of chronic, intractable pain associated with cancer". There are now seven different brands available including the PAJF choice – Matrifen®.

Since their introduction, the licensed indications have morphed from cancer related pain to simply: "Severe chronic pain, which can be adequately managed only with opioid analgesics" (current licence for Matrifen®). This in turn has led to these patches being used in a wider group of patients, many of whom are not terminally ill - those with chronic pain.

Chronic pain treatment is potentially going to last a long time. This poses three issues:

1) increasing tolerance in patients – what do you do if pain is not controlled?
2) risks of long-term opioid use – endocrine and immunological
3) long term high cost!

Fentanyl patches are generally considered a last line of treatment and are not recommended by the pain clinic for the treatment of persistent non-cancer pain. The implications of the three points above would need careful consideration before initiating treatment with fentanyl patches.

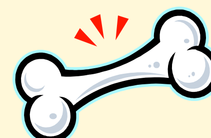
A very useful document on treating persistent pain is found at:
http://www.britishpainsociety.org/book_opioids_recommendations.pdf

Do antiepileptics increase the risk of osteoporosis?

Since 2009 the MHRA have advised that long term treatment with phenytoin, carbamazepine, primidone and sodium valproate are associated with decreased bone mineral density. This in turn may lead to osteopenia, osteoporosis and increased fractures, particularly in "at-risk" patients. Vitamin D supplementation should be considered for "at-risk" patients who are taking these medicines long term.

"At-risk" patients are defined as:

1. Those who are immobilized for long periods.
2. Those who have inadequate sun exposure.
3. Those with inadequate dietary calcium intake.
4. Those over 50 years old.



Healthcare professionals are encouraged to review this group of patients and consider the above recommendation.

NPSA Lithium alert reminder

GP Practices and pharmacies are reminded that all patients taking lithium should now have a "purple book". If a patient does not have a purple book then pharmacies should contact the surgery to confirm that monitoring requirements are up to date. The patient should then be referred back to the practice to get a book.

Practices were sent two purple book packs in November and further supplies are available from Primary Care Support Services (PCSS) (Fax 01392 445431) or ordered via d-pc.pcssstationery@nhs.net

NPSA lithium alert letter 30.11.10 - Correction:
N.B. Correction to lithium alert letter sent to practices and pharmacies on 30.11.10: Telephone number for the duty biochemist quoted in this letter is incorrect. It should be: 01752 5179**36**. We apologise for any confusion that this may have caused.

MHRA Drug Safety Update summary : March 2011

Modafinil (Provigil): Further information is available to support safer use, including: cautions for use; criteria for stopping treatment; and monitoring requirements during treatment. Now restricted to narcolepsy.

Natalizumab (Tysabri▼): risk of progressive multifocal leukoencephalopathy is increased in patients who have had previous immunosuppressant treatment. Prescribers should ensure that patients are aware of this updated advice to help minimise the risk of PML.

For further information:
http://www.mhra.gov.uk

While every effort is made to ensure the accuracy of information in this newsletter, for full prescribing information on any of the drugs mentioned please consult individual Data Sheets, Summaries of Product Characteristics and the current BNF.