The T@blet

News from the Medicines Management Team

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PRIORITY INFORMATION

DRUG SAFETY UPDATE

Domperidone for nausea and vomiting: lack of efficacy in children; reminder of contraindications in adults and adolescents

Domperidone is no longer licensed for use in children younger than 12 years or those weighing less than 35 kg. This follows an absence of data for benefit, including findings from a placebo-controlled study in children with acute gastroenteritis that did not show domperidone to be more effective than placebo at relieving nausea and vomiting. We also remind healthcare professionals of contraindications and recommendations for dose and treatment duration in adults and adolescents introduced in 2014.

E-cigarette use or vaping: reporting suspected adverse reactions, including lung injury

Be vigilant for any suspected adverse reactions associated with use of e-cigarettes or

vaping (including lung injury) and report them to the MHRA via the Yellow Card Scheme.

For full article Click here

Ondansetron: small increased risk of oral clefts following use in the first 12 weeks of pregnancy

Recent epidemiological studies suggest exposure to ondansetron during the first trimester of pregnancy is associated with a small increased risk of the baby having a cleft lip and/or cleft palate.

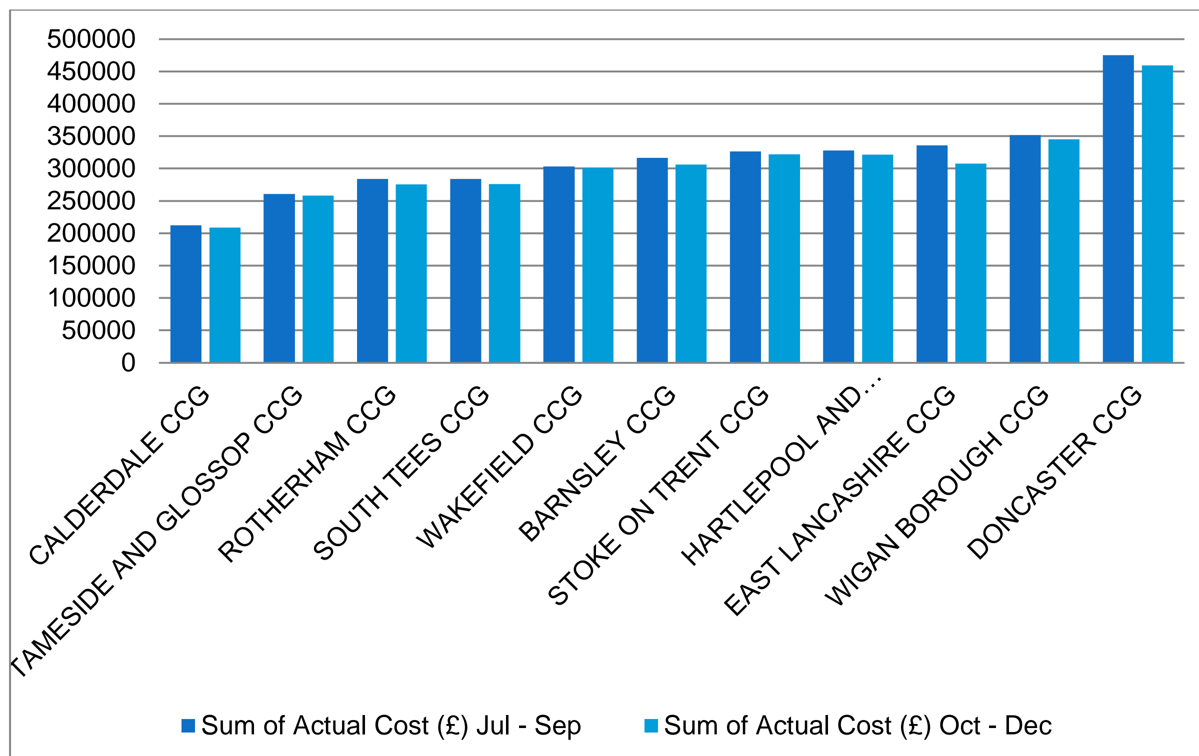
For full article Click here

PRODUCT SHORTAGE GUIDE

Due to the large number of out of stocks, a guide has been provided to the CCG. This has been provided to your practice or PCN pharmacists.

OTC UPDATE

We currently stand out significantly from our 10 other similar CCGs:



We have prepared a guide of FAQs to use when receptionists/ clerks or even yourselves are queried by patients. This can be found on the CCG self-care resource page.

We have also prepared a spreadsheet tool – OTC variance by practice that shows the spend difference per practice over the last year.

For general enquiries please email: donccg.medicinesmanagementadmin@nhs.net

For practice pharmacist queries please email: donccg.rxline@nhs.net

We would in particular like to thank Denaby, Rossington, Northfield, Flying Scotsman and St Vincent's for making the largest cost based reduction in prescribing in the last year in their respective localities.

INFORMATION

SMART GUIDE TO MEDICINES MANAGEMENT

The updated Smart Guide to Medicines Management has been added to the Medicines Management website, this is a useful aid for health care professionals and could be used for staff inductions in practice.

To access the smart guide Click Here

QUIT PROGRAM (STOP SMOKING)

QUIT is the systematic implementation, at scale, of the treatment of tobacco dependency in secondary care and the provision of ongoing support for people to QUIT smoking from community stop smoking services or the specialist mental health stop smoking advisors.

GP practices should refer smoking cessation patients to the specialist service and should not pick up patients who may attend for smoking cessation therapy post discharge.

APC PRESCRIBING COMMITTEE JANUARY 2020 UPDATE

- **Benilumab** (Benlysta) used for SLE has been classified as **RED**
- **Dupilumab** (Dupixent) used for chronic rhinosinusitis with nasal polyposis has been classified as **Grey 2**
- **Melatonin 3mg** tablets for jet lag has been classified as **Grey 5**
- **Alimemazine** (Zentiva, ADVANZ, Pharma, Thame laborotaries) used as a sedating antihistamine in urticaria and pruritus is not a cost effectice choice and there are other antihistamines available which are licensed for use in these indications and so this has been classified as **Grey 5**.

OPIOID PRESCRIBING – ORAL MORPHINE EQUIVALENT DOSES

There has been a marked increase in the number of patients in the UK taking opioids from 2.5% in 2000, to 5% in 2015. In addition, according to a Faculty of Pain Medicine report, more patients are taking opioids at higher doses for chronic pain. However, opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain. Moreover, the risk of harm from opioids increases substantially at doses above an oral morphine equivalent of 120mg/day.

The table below outlines the oral morphine equivalent (OME) doses of different opioid medication. However, it is worth noting that conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation.
The following key tips provided by the Faculty of Pain Medicine (FPM) are useful:

- Always calculate doses using morphine as standard and to adjust them to suit the patient and the situation

- Consider making a reduction in morphine equivalence dose of 20 - 50% when changing drugs.
- Caution should be used in renal and hepatic failure.
- Avoid patch use in unstable pain.

The FPM has also provided guidance on how to taper/ stop an established opioid regimen in primary care, which can be accessed here.

Opioid equivalence table (values are approximate) – adapted from Specialist Pharmacist Service

Morphine	**Oxycodone**	**Fentanyl**	**Buprenorphine**	**Codeine phosphate/ Dihydrocodeine**	**Tramadol**
Oral (mg)	Oral (mg)	Transdermal patch (mcg/hr)	Transdermal patch (mcg/hr)	Oral (mg)	Oral (mg)
24hr total dose	24hr total dose	Patch strength STABLE PAIN ONLY	Patch strength STABLE PAIN ONLY	24hr total dose	24hr total dose
5				60	50
10			5 Butrans®	120	100
15					150
20	10		10 Butrans®	240	200
30	15				300
40	20	12	20 Butrans®		400
60	30		35 Transtec®		
80	40	25			
100	50		52.5 Transtec®		
120	60				
Doses above this level are not recommended in chronic pain If patient is still complaining of pain despite opioids at this level, then opioids are not working and should be reduced and stopped even if there is no other treatment available					
140	70	37	70 Transtec®		
160	80				
180	90	50	105 Transtec®		
200	100				
240	120	62			
280	140	75			
320	160		140 Transtec®		
360	180	100			

QUALITY TOOLKIT FOR CARE HOMES

This toolkit is available online in chapter format. It contains information on homely remedies, self-care, covert administration and as required medication.

COMMUNITY TREATMENT ORDERS AND THE MENTAL HEALTH ACT

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Rotherham Doncaster & South Humber NHS Trust (RDASH) have alerted us of a number of incidents recently where patients subject to Community Treatment Orders [CTO] have been prescribed medicines outside of those allowed under their CTO.

A briefing has been sent out by the Chief Pharmacist in RDASH to all practices via the Primary Care Team to highlight the restrictions which apply to prescribing in these circumstances.

Briefly, when a patient is under a CTO, the Mental Health Act [MHA] rules regarding 'consent to treatment' apply. After the initial month, treatment with medicines for mental disorder must be certified as appropriate for treating that patient's disorder by the Responsible Clinician (i.e. Consultant Psychiatrist) on either a CTO11 or CTO12 Form. If a clinician prescribes (or someone administers a medicine) outside of conditions outlined in these forms, they are in breach of the MHA and subsequently at risk of litigation.

If practices have a patient who has a CTO in place, then they will get a letter from the Chief Medical Officer at RDASH. This should be recorded on the patient record system with SNoMEd code SCTID: 371451000000108 - Subject to community treatment order under Section 17A of Mental Health Act 1983 (England and Wales)

More information on CTO and MHA is available via the briefing sent out to practices by the Chief Pharmacist of RDASH.