MEDICINES MANAGEMENT
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theT@blet

News from **Medicines Management** at **Doncaster Clinical Commissioning Group**

NICE NG 23 Menopause: Diagnosis and management

The guideline aims to improve the consistency of support and information provided to women in menopause. It covers diagnosis, drug and non-drug treatments that can help with symptoms, and offers clarity on the risks and benefits of HRT.

Key points:

- HRT is recommended for hot flushes and night sweats, after discussing risk: benefit.
- HRT is an option (as well as cognitive behavioural therapy) to alleviate low mood that arises as a result of menopause.
- HRT does not increase cardiovascular disease (CVD) when started in women aged under 60 years.
- HRT does not affect the risk of dying from CVD.
- Consider transdermal rather than oral HRT for menopausal women who are at increased risk of VTE, including those with a BMI over 30kg/m2
- HRT is not associated with an increased risk of developing type 2 diabetes.
- Oestrogen-only HRT has little or no increase in the risk of breast cancer.
- HRT with oestrogen and progestogen can be associated with an increase in the risk of breast cancer but any increase risk reduces after stopping HRT.
- Offer vaginal oestrogen to women with urogenital atrophy.
- NICE CKS - Menopause (Hormone Replacement Therapy).

Antispasmodics - drug choice and costs

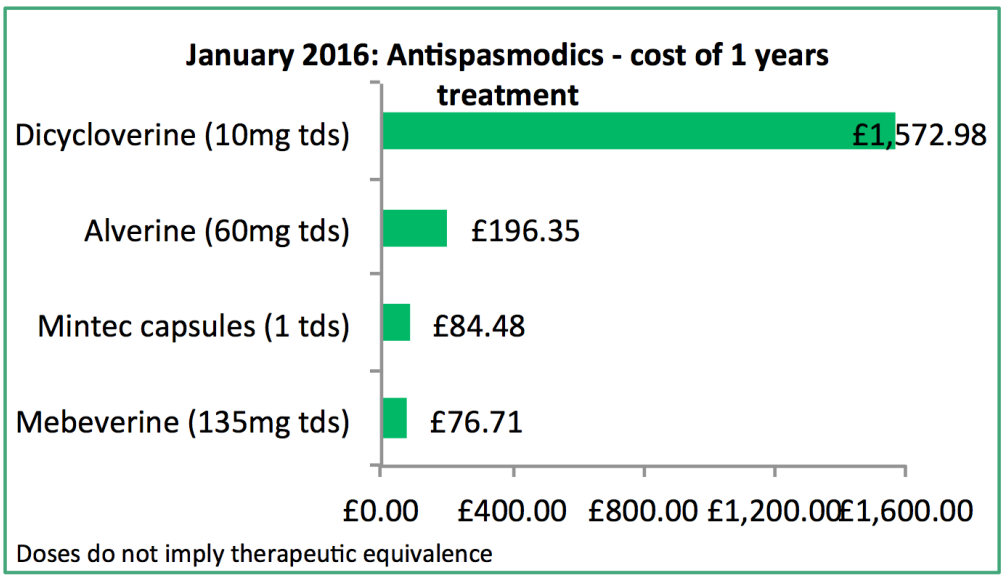
There is little difference in efficacy between different antispasmodics and dicycloverine is an expensive option.

In addition, anti-muscarinics such as dicycloverine and hyoscine butylbromide are more likely to cause adverse effects than direct-acting smooth muscle relaxants such as mebeverine or peppermint oil.

Action:

a) For all patients with irritable bowel syndrome, and in particular those with pain occurring as spasm, consider mebeverine 135mg tablets or Mintec capsules first line alongside dietary and lifestyle advice.
b) Consider review of patients receiving dicycloverine who have not previously tried mebeverine or Mintec.

NICE CKS - Irritable bowel syndrome
Doncaster & Bassetlaw Medicines Formulary - Section 1.2



Antibiotic spotlight – Epididymo-orchitis

If gram-negative enteric organisms likely the 1st line antibiotic choice is: Ciprofloxacin 500mg BD for 10 days.

How do you switch between tricyclic, SSRI and related antidepressants?

Summary:

- Care is required when switching between antidepressants.
- When switching between selective serotonin reuptake inhibitors, tricyclic and related antidepressants, it is considered safer, in order to avoid inducing a drug discontinuation syndrome or precipitating drug interactions, to incrementally reduce the dose of the first antidepressant and discontinue it before starting the second antidepressant. This is not always possible. In severely depressed patients who have failed to respond to one antidepressant, or in cases of severe adverse reaction, it may be necessary to shorten the process of substitution.
- Cross-tapering is an option for some switches but should always be done cautiously.
- Patients should be assessed on an individual basis to determine how quickly the switch can be done.

Management of anti-thrombotic therapy in atrial fibrillation (AF) patient who develop acute coronary syndrome (ACS)

The optimal strategy to balance the risk of bleeding events and recurrent ischaemic events in people needing antiplatelets and anticoagulants is subject to debate as specifically designed and powered studies are not available. The choice of therapy and its duration is individualised, based on atherothrombotic risk, cardioembolic risk, and bleeding risk.

European guidelines advise on the choice of therapy (i.e. anticoagulant + single or dual antiplatelet therapy) in AF patients with ACS according to the clinical setting and stroke risk versus bleeding risk.

- The routine use of P2Y12 inhibitors (prasugrel and ticagrelor) in combination with a NOAC is not recommended due to the increased risk of major bleeding.
- The period of dual antiplatelet therapy plus anticoagulant should be as short as possible (e.g. not exceeding 6 months for patients at low risk of bleeding or 4 weeks for patients at high risk of bleeding (e.g. HAS-BLED ≥3)). This can be followed by single antiplatelet therapy plus anticoagulant for up to 12 months then lifelong anticoagulant.
- Where a NOAC is used with an antiplatelet, the lowest effective dose to reduce the risk of stroke should be considered.
- Gastroprotection with lansoprazole should be considered in all patients on any combination of antiplatelets and anticoagulants.

Patients with stable coronary artery disease (arbitrarily defined by European guidelines as being free from any acute ischaemic event or repeat revascularisation for over one year) and concurrent AF can be managed with anticoagulation alone.

UKMi Q&A 224.1 - What are the risks of using antiplatelet agents in combination with the Novel Oral Anticoagulants (NOACs) in patients with atrial fibrillation and how should the potential risks be managed?

Formulary changes

Drug	Change	Rationale	Comments
Ibuprofen 600mg & 800mg oral	Removed	Removal supports MHRA recommendations re high dose ibuprofen and CV risk. Cost. Low usage	Ibuprofen 200mg and 400mg tablets remain in Formulary.
Naproxen gastro-resistant (EC) oral	Removed	No additional clinical benefit. Cost. Low usage.	Naproxen 250mg and 500mg tablets remain in Formulary.
Indometacin & Diclofenac oral	Removed	Removal supports MHRA recommendations re CV & GI risk.	Diclofenac suppositories & injection remain in Formulary.
Exenatide 2mg MR suspension for injection	Removed	Replaced by Dulaglutide 1.5mg weekly preparation.	Liraglutide 6mg/ml injection remains in Formulary for daily administration.
Dulaglutide 1.5mg solution for injection (weekly admin)	Added	Favourable patient acceptability factors.	

Oral contraceptives discontinued

The following oral contraceptives are due to be discontinued during 2016. The planned discontinuations are not related to any safety, quality or efficacy issues.

Product Name	Active Ingredient(s)	Anticipated Discontinuation Date
Trinovum	Norethisterone (0.5mg, 0.75mg, 1.0mg) and ethinylestradiol 0.035mg	End of January 2016
Ovysmen	Norethisterone 0.5mg and ethinylestradiol 0.035mg	April 2016
Binovum	Norethisterone (0.5mg, 1.0mg) and ethinylestradiol 0.035mg	June 2016

Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain

The Faculty of Pain Medicine has developed a new resource to support the safe and rational use of opioid medicines. Content includes best professional practice, a structured approach to prescribing opioids and information for patients.

1. 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.
2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

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