Produced by the NHS Rotherham Medicines Management Team
Tel (01709) 302639 if further information required.

Bite Size Prescribing News April 2014

NHS Rotherham

Changes to the Stop Smoking Service

Rotherham public health has changed the way stop smoking services are provided to patients.

What practices should do,

- Continue to prescribe for any patient that was collecting prescriptions for NRT products prior to 1st April 2014 until they have completed their course
- Do not prescribe for any new patients.
- Patients that visit the stop smoking service should receive a voucher from that service for any products that they require.
- Patients should never have to request the GP practice to prescribe any products for them
- Patients may be denied product from the stop smoking service if they do not fulfil the services criteria. In such instances the practice should not provide products for these patients.
- Varenicline will also be supplied from pharmacies, via a PGD against a voucher
- If the practice wishes to participate in the stop smoking LES, they should have received a supply of stop smoking vouchers.
- All practices will be invited to participate in a new stop smoking LES in June 2014

For further information contact.

Service Commissioner

Alison Iliff
Public Health Principal (Health Improvement)
Rotherham Public Health
01709 255848

Operational queries

Simon or Jackie
Stop smoking service
01709 422444

The Following Items may be in short supply or available only at above drug tariff prices from April 2014 for a couple of months or longer

- Co-amilofruse 5/40 tablets (28) – £5.29
- Co-Amoxiclav 500/125 tablets (21) – £6.93
- Co-Tenidone 50/12.5mg tablets (28) - £5.18
- Co-Tenidone 100/25mg tablets (28) - £5.18
- Piroxicam 0.5% gel (60g) - £6.00
- Piroxicam 0.5% gel (112g) - £9.41
- Propranolol 10mg tablets (28) – £5.30
- Propranolol 40mg tablets (28) – £4.60
- Propranolol 80mg tablets (56) – £6.44

MHRA places restrictions on the use of domperidone due to cardiac side effects.

Advice for healthcare professionals

Indication

• Domperidone is now restricted to use in the relief of symptoms nausea and vomiting
• It should be used at the lowest effective dose for the shortest possible time

Contraindications

• Domperidone is contraindicated in people:
- with conditions where the cardiac conduction is, or could be, impaired
- with underlying cardiac diseases such as congestive heart failure
- receiving other medications known to prolong QT or potent CYP3A4 inhibitors
- with severe hepatic impairment
• Patients with these conditions should have their treatment reviewed at their next routine appointment and be switched to an alternative treatment if required

Posology

Oral formulations

• For adults and adolescents over 12 years of age and weighing 35kg or more, the recommended maximum dose in 24 hours is 30mg (dose interval: 10mg up to three times a day)
• In children under 12 years of age and weighing less than 35kg, the recommended maximum dose in 24 hours is 0.75mg/kg body weight (dose interval: 0.25mg/kg body weight up to three times a day)

Suppository formulation (**Discontinued**)

• Suppositories should only be used in adults and adolescents weighing 35kg or more, the recommended maximum daily dose in 24 hours is 60mg (dose interval: 30mg twice a day)

Duration of treatment

• The maximum treatment duration should not exceed one week
• Patients currently receiving long-term treatment with domperidone should be reassessed at a routine appointment to advise on treatment continuation, dose change, or cessation

COPD: risk of pneumonia with inhaled corticosteroids

Two[1,2] recently published articles have again highlighted the risk of serious pneumonia in people with chronic obstructive pulmonary disease (COPD) using inhaled corticosteroids (ICS).

The first of the new articles, a Canadian population-based cohort study of 163,514 people receiving new treatment for COPD[1], attempted to assess whether ICS (budesonide or fluticasone propionate (FP) in particular) vary in their tendency to increase the risk of pneumonia and to evaluate the dose-response effects.

Over a mean follow-up of 5.4 years, 20,344 patients had serious pneumonia (defined as hospital admission n=19,667; or death n=677). After adjusting for various factors such as age, sex, severity of respiratory disease, current use of ICS was associated with:

- **69% relative increase in the rate of serious pneumonia (rate ratio [RR] 1.69, 95% CI 1.63 to 1.75).**
- **This risk appeared to increase with the dose of ICS, ranging from a 24% relative increase in the rate of serious pneumonia with low doses (equivalent to less than 500 mcg/day of FP) to 86% with high doses (equivalent to at least 1000 mcg/day of FP).**

The second is a Cochrane Database of Systematic Review on inhaled steroids and risk of pneumonia for chronic obstructive pulmonary disease. This review found 43 studies that met the inclusion criteria. The authors concluded that:

"budesonide and fluticasone, delivered alone or in combination with a LABA, are associated with increased risk of serious adverse pneumonia events, but neither significantly affected mortality compared with controls".

NICE guidance[3] on the management of COPD recommends inhaled corticosteroids (ICS) in combination with other inhaled therapies for selected patients, as part of the range of treatment options. The guidance advises practitioners to be aware of the potential risk of side effects (including non-fatal pneumonia) in people with COPD treated with ICS.

The MHRA[4] has advised that treatment with an ICS in COPD – either alone or in combination with a long-acting beta-agonist (LABA) – significantly increases the risk of pneumonia.

In the TORCH[5] randomised controlled trial (RCT) the probability of pneumonia was 19.6% in the fluticasone propionate/salmeterol group and 18.3% with fluticasone propionate alone compared with 12.3% in the placebo group.

These new articles reinforce the need for healthcare professionals to be aware of the potential risk of side effects in people with COPD treated with ICS, along with the potential benefits, and be prepared to discuss these with patients. Only ICS in combination inhalers are licensed for treating COPD. Three products are currently licensed for this indication: Seretide Accuhaler, Symbicort and Relvar Ellipta.

References:

1) Suissa S, Patenaude V, Lapi F, et al (2013) Inhaled corticosteroids in COPD and the risk of serious pneumonia. Thorax 68:1029–36
2) Kew KM, Seniukovich A. Inhaled steroids and risk of pneumonia for chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2014, Issue 3. Art. No.: CD010115. DOI: 10.1002/14651858.CD010115.pub2.
3) NICE CG101 - Management of chronic obstructive pulmonary disease in adults in primary and secondary care:June 2010
4) MHRA Drug Safety Update - Use of long-acting β-agonists in chronic obstructive pulmonary disease. July 2009;2:12
5) Calverley PM, et al. Salmeterol and fluticasone propionate and survival in chronic obstructive pulmonary disease. New Engl J Med 2007; 356: 775–89.