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| cross-ver-bb-sml-1830Produced by the NHS Rotherham CCGMedicines Management TeamTel (01709) 302639 if furtherinformation is required. |  | R:\Templates\RCCG_Full_Col_Logo_CMYK.jpg |

**Antibiotics**

An updated version of the joint CCG/TRFT Antimicrobial protocol for the Management of Infection in Primary Care is now on the CCG internet site (<http://www.rotherhamccg.nhs.uk/therapeutic-guidelines.htm#Infections>). Alongside this protocol on the site is the document showing arrangements for the access to antimicrobials for community-based patients with infections in whom Fosfomycin, Linezolid, Tedizolid or Fidaxomycin are the only treatment options.

The overall use of antibiotics across the CCG is still high and all prescribers are reminded to **only use antibiotics when absolutely necessary.**

**Levetiracetam containing products 100 mg/mL oral solution presentations: Risk of medication errors associated with overdose.**

National cases of an up to 10‐fold accidental overdose with Keppra® (levetiracetam) oral solution have been reported. The majority of cases occurred in children aged between 6 months and 11 years.

Physicians should always prescribe the dose in mg with mL equivalence based on the correct

age. Levetiracetam overdose can lead to serious adverse events, like depressed level of consciousness,

respiratory depression and coma. In the cases where the cause of the reported accidental overdosing could be retrieved, it was either due to the use of an inappropriate syringe or the misunderstanding of the caregiver about how to properly measure the dose.

Physicians should prescribe the recommended presentation of Keppra® oral solution with the appropriate syringe according to the age/bodyweight of the patient. The pharmacist should ensure the right syringe is dispensed with the corresponding presentation:

* 150 mL bottle with 1 mL syringe for infants from 1 month to less than 6 months;
* 150 mL bottle with 3 mL syringe for children 6 months to less than 4 years and below 50 kg

bodyweight;

* 300 mL bottle with 10 mL syringe for children 4 years and older and below 50 kg

bodyweight;

* 300 mL bottle with 10 mL syringe for children, adolescents and adults with 50 kg and more

bodyweight.

**Depakote stock issues:** There are stock issues with Depakote® 250mg tablets. If the dose cannot be made up using 500mg tablets consider the following information.

Depakote® 500mg contains 500mg valproic acid

Sodium Valproate 500mg contains 433mg valproic acid

Although sodium valproate is not licensed as an antimanic/mood stabiliser NICE supports its use in bipolar disorder. RDaSH have also recommended that sodium valproate may be used where necessary. Some dose rounding up may be necessary.

**Branded generic of the month**: Alzain® is a brand of pregabalin which is 30% cheaper than the current list price (based on Lyrica®) All pregabalin for any indication other than neuropathic pain (which we will look at again in July 2017 when the current patent for Lyrica® and neuropathic pain expires) will be changed to Alzain®.

As you know there have been issues registering and deregistering GPs since the demise of the South Yorkshire Agency and the world being run by Capita.

Well it appears that **Stuart Lakin** now has the power to register and deregister GPs with the PPD!

* All new GPs……..Send their details to Stuart
* Any GPs that leave a practice or spontaneously combust while at work…….. Send their details to Stuart.

Details needed:

* Full name & GMC Number
* GP DIN number
* Name of practice and start date or leaving date

**Diabetes update**

GLP-1 (Glucagon-like peptide 1)

Glucagon-like peptide 1 is a naturally occurring peptide that ultimately stimulates insulin release. The GLP-1 drugs are modified versions of endogenous GLP-1 and range from 50% to 97% commonality with natural GLP-1.

The [NHS Rotherham GLP-1 pathway](http://www.rotherhamccg.nhs.uk/therapeutic-guidelines.htm#Endocrine) has been uploaded onto the CCGs intranet (it prints best as A3 size).

**GLP-1 summary**

* GLP-1’s are more potent at HbA1c lowering than most oral antidiabetic drugs and cause weight loss.
* Although relatively new drugs the trial data to date has not demonstrated an increase in cardiovascular end points, although as a class GLP-1’s may cause a moderate increase in heart rate, typically by less than 2 beats\minute.
* Once weekly GLP-1’s are better than daily at lowering HbA1c.
* Daily GLP-1’s are better at lowering postprandial blood glucose and promoting satiety.
* Daily GLP-1’s have more central side effects such as dizziness, fatigue, drowsiness, headache.
* All GLP-1’s have GI side effects such as dyspepsia, reflux, abdominal distention & pain, nausea, vomiting, diarrhoea and constipation.
* GLP-1’s can be used as monotherapy or in combination with metformin, SGLT-2’s (Flozin) Sulphonylureas, pioglitazone and insulins.
* The use of GLP-1’s in combination with other antidiabetic drugs depends on their individual license. Follow the Rotherham GLP-1 pathway to prevent the use of unlicensed combinations.
* Do not prescribe a GLP-1 in combination with a DPP4-I (Gliptin) as they both work on the same pathway. GLP-1’s stimulate incretin which stimulates insulin release. A DDP-4I (Gliptin) prevents the breakdown of endogenous GLP-1. There is no synergy between the GLP-1’s and DDP-4I’s (Gliptin) therefore there is no benefit in using the two together.

**Metformin + Linagliptin + Empagliflozin asuccessful combination.**

The Rotherham diabetes guidelines recommend these three agents in this order. A recent double blind study evaluated the addition of empagliflozin or placebo to patients already taking metformin & linagliptin. After 24 weeks empagliflozin significantly reduced HbA1c (-0.79%) compared to placebo. Fasting blood glucose and weight loss were significantly reduced with empagliflozin and more patients taking placebo (68.2%) reported adverse effects than with emapgliflozin (51.8-55.4%) Diabetes Care 2016 dc 16-1347

**Sulphonylureas and Cardiovascular events.**

NICE guidance; Type 2 diabetes in adults management (July 2016) concluded that sulphonylureas (SU) are cardiovascular neutral. However, a recent meta-analysis of 108 trials with SU’s observed that the risk of an MI was significantly higher with an SU than a DDP-4I (Gliptin) or a SGLT2 (Flozin). The risk of stroke was significantly higher with an SU than a DDP-4I (Gliptin) GLP-1 pioglitazone and insulin.

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**Contact the medicine management team if you would like the GLP-1 pathway presented/discussed at a practice PLT**

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