NHS Forth Valley

Prescriberfile

From the Primary Care Prescribing Group

Topiramate in patients of childbearing potential

Topiramate is a known teratogen and is associated with an increased risk of major congenital malformations (MHRA January 2021). There are also concerns that topiramate may be associated with poorer developmental outcomes.

Topiramate is also an enzyme inducing drug and reduces the efficacy of both combined hormonal contraception (oral, patches and vaginal rings), and progesterone-only contraception (oral, and subdermal implants).

Topiramate is licensed as a treatment for epilepsy and for prophylaxis of migraine. Topiramate is normally initiated by a specialist however it is recognised that topiramate is sometimes started by GPs for migraine prophylaxis.

The Summary of Product Characteristics state that in both indications, **highly effective contraception** is required where topiramate is being prescribed in women of childbearing potential, and the patient must be fully informed of the potential risks of the drug to the foetus. In the case of migraine prophylaxis, lack of appropriate contraception is a contraindication to use of topiramate.

For women on teratogenic medicines, the Faculty of Sexual and Reproductive Healthcare (FSRH) consider the following methods 'highly effective':

- copper intrauterine device (Cu-IUD),
- levonorgestrel intrauterine system (LNG-IUS)
- progestogen-only implant (IMP) [**NB: NOT in patients taking enzyme-inducing drugs such as topiramate – see** FSRH interactions info]
- male and female sterilisation

All of the above methods have a failure rate of less than 1% with typical use.
FSRH do not consider Depo Provera (depot medroxyprogesterone acetate (DMPA)) used alone to be a highly-effective method (it has a failure rate of 6%).

The Primary Care Prescribing Group strongly recommend that all GP Practices undertake the following actions:

- Run an EMIS search to find female patients (including trans men) aged 12-54 currently prescribed topiramate.
- Review any identified patients to ensure that the patient is on highly-effective contraception which is not affected by topiramate as appropriate to circumstances and indication – **Intrauterine Contraception (Cu-IUD or LNG-IUS) should be considered first-line.**

  Where this is not appropriate or not acceptable, use of DMPA can be considered, but as typical failure rate is estimated at 6%, condoms should be used in addition during use of the topiramate.

Soya and Nut allergy cross-sensitivity

A number of products in EMIS PCS have warnings for either soya or peanut allergy.

Prescribers should be aware that:

- there is a possible relationship between soya and peanut allergies
- patients with peanut allergies should also avoid any item with a soya warning (and vice versa).

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Please Circulate to All Staff

Inside this issue:

Supply issues

For the latest Supply Issues affecting Primary Care and local associated guidance see here

Key Points of interest:

- Review all female patients (incl. trans men) aged 12-54 currently prescribed topiramate for appropriate highly-effective contraception.
- Beware of soya and nut allergy cross sensitivity.
- Prescribe modafinil within its licensed indication only.
- Restrict betahistine to Ménière's disease.
- Topical corticosteroids: steroid withdrawal reactions.

Reduce harm, waste and unwarranted variation

1 in 10 medicines unnecessary

NHS England recently published a review estimating 10% of items dispensed in primary care are over prescribed with 15% of people taking 5 or more medicines a day and approximately 1 in 5 hospital admissions in over-65s caused by the adverse effects of medicines. In Scotland, Realistic Medicine, recognises these challenges and by putting the patient at the centre of decisions made about their care we can improve the quality of prescribing. National and local learning and support tools are available to help embed Realistic Medicine into your daily practice. Forth Valley also recently hosted a Realistic Medicine Symposium. Three areas identified for prescribing improvement by the Primary Care Prescribing Group are highlighted below.

Modafinil—review off-label use

Local specialists during a recent review of the CNS section of the Forth Valley Formulary expressed concern on:

- number of patients prescribed modafinil
- use for unlicensed indications

Modafinil is an oral 'wakefulness-promoting' agent acting on the central nervous system. In August 2010 the MHRA restricted the use of modafinil to the treatment of narcolepsy (with or without cataplexy) following post-marketing data that demonstrated modafinil can cause serious adverse effects including psychiatric disorders, cardiovascular symptoms and serious skin and multi-organ hypersensitivity reactions.

Modafinil **should no longer be used** for the treatment of excessive sleepiness associated with obstructive sleep apnoea or chronic shift work sleep disorder. The manufacturer advises that the long-term efficacy of modafinil has not been assessed (> 9 weeks) and prescribing should be periodically re-evaluated.

A recent audit identified off-label use of modafinil in Forth Valley.

GP practices are reminded to

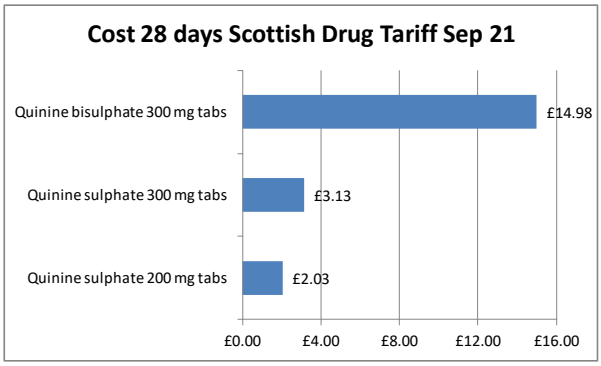
- Limit prescribing of modafinil to the treatment of excessive sleepiness associated with narcolepsy in adults, with or without cataplexy.
- Review all patients to ensure continued benefit.
- Monitor all patients for the potential risk of serious adverse drug reactions and advise of them of the risks.
- Review modafinil in off-label conditions to reduce inappropriate prescribing where there is insufficient evidence of efficacy and safety
- Refer patients prescribed modafinil for off-label indications to the initiating specialist service for review.

Quinine salts for leg cramps

The BNF and MHRA do not recommend quinine for the routine treatment of nocturnal leg cramps because of potential toxicity, unless cramps cause regular disruption to sleep. . Quinine is toxic in over-dosage and fatalities have occurred.

Quinine should only be considered when cramps are very painful or frequent, when other treatable causes of cramp have been excluded, and when non-pharmacological treatments have not worked (e.g. passive stretching exercises).

Long term treatment should be interrupted (trial discontinuation) at intervals of approximately three months.



Key points:

- All new patients considered for quinine should have a initial trial of 4 weeks — stop if no benefit.
- Stop treatment if presenting with adverse event such as tinnitus, impaired hearing, headache, nausea, disturbed vision, confusion, flushing, abdominal pain and rarely thrombocytopenia.
- Long term treatment should be interrupted (trial discontinuation) after 3 months to assess the need for further quinine treatment.
- Where quinine salts are continued, prescribe the lowest dose to manage symptoms and the most cost effective treatment, currently quinine **sulphate 200 mg tablets**
- Patients prescribed quinine bisulphate 300 mg tablets should be reviewed and considered for quinine sulphate 200 mg or 300mg tablets.
- Quinine has dose-dependent QT-interval-prolonging effects and should be used with caution in patients with risk factors for QT prolongation or in those with atrioventricular block or on other QT-interval-prolonging drugs.

Reduce harm, waste and unwarranted variation (continued)

Betahistine—only for confirmed Ménière's disease

The Forth Valley Formulary status of betahistine recently changed. **Betahistine is only recommended for use in patients with Ménière's disease (MD) following diagnosis by an ENT specialist**. This change is supported by the New Drugs & Formulary Group and the Primary Care Prescribing Group.

Betahistine is only licensed for Ménière's disease, a rare disease with an incidence of 13.1 per 100,000 person-years; a GP would see a few presentations of Ménière's disease during a whole career. However, prescribing data suggests more common use than would be expected for the restricted indication. Several Cochrane reviews have concluded that betahistine is unlikely to be effective in vertigo, tinnitus or Ménière's disease . The BMJ concluded in 2016 that many patients continue to take betahistine and many doctors continue to prescribe it, possibly because of the drug's high tolerance, low risks, and lack of alternatives.

It is recommended that

- Patients with suspected Ménière's disease should be referred to ENT for confirmation of diagnosis and appropriate treatment.
- No new patients should be initiated on betahistine in primary care without ENT specialist involvement.
- Review all existing patients prescribed betahistine for unlicensed indications; treatment should be stopped if there is no benefit.
- Patient resources on non-pharmacological options for dizziness are being developed by Forth Valley ENT department.

Updates to the NHS Forth Valley Formulary

The following changes to the Forth Valley Formulary have been agreed by the New Drugs & Formulary Group. Additions and deletions of medicines are based on formulary submissions, new drug assessment requests or formulary section reviews. ADTC decisions relating to SMC assessments can be accessed here. Relevant messages will be added to *ScriptSwitch*® to support prescribers in primary care.

Analgesia

Key changes to the opioid section:

- **Co-codamol 15/500 tablets** added to the Formulary. For all co-codamol preparations tablets/caplets are preferred.
- **Butec® patches** (buprenorphine 7 day patch) added to the formulary—prescribe as preferred brand.
- **Zomorph® capsules** (morphine sulphate) are the preferred choice in new patients requiring a modified release morphine preparation. For patients who cannot swallow capsules, contents can be administered directly in semi-solid food (puree, jam, yoghurt) or via an appropriate size gastric or gastrostomy tube. Morphgesic® no longer preferred.
- **Brand name prescribing is recommended for all strong opioids to reduce the risk of confusion and error in dispensing and administration**.

Key changes to the neuropathic section:

- **Nortriptyline** added as a *2nd line* choice in patients intolerant to amitriptyline.
- **Duloxetine 30 mg and 60 mg capsules** is the preferred *2nd line* choice in new patients for neuropathic pain, in preference to gabapentinoids.
- **Qutenza® patches** (capsaicin) are *Specialist Use Only* and should not be prescribed in Primary Care as application needs to be undertaken under the supervision of a physician.

Change in Formulary status for clomifene from Hospital use only to Specialist initiation and continuation in Primary Care.

Mental Health

Key changes for Attention Deficit Hyperactivity Disorder (ADHD):

- The 1st, 2nd and 3rd line choices for the management of ADHD were clarified.
- **Xaggitin® XL** is the preferred methylphenidate modified release preparation.

Key changes for melatonin in Neurodevelopmental Disorders:

- The use of crushed melatonin M/R preparations in patients with swallowing problems is not supported due to the availability of other licensed formulations
- Wherever clinically appropriate prescribe the licensed melatonin formulations and strengths listed:
  - ⇒ 1st line: melatonin 3 mg tablets.
  - ⇒ 2nd line: melatonin 1 mg, 2 mg and 5 mg modified release tablets; or melatonin 2 mg, 3 mg, 5 mg immediate release capsules.
  - ⇒ 3rd line: melatonin 1 mg/ml sugar free oral solution.

Drug Safety Updates

Selected highlights from recent Drug Safety Update Bulletins from the MHRA (https://www.gov.uk/drug-safety-update). Click on titles in boxes for links to the full MHRA Drug Safety article.

Prescribers are encouraged to subscribe directly to the Drug Safety Updates Bulletin which is only available by email.
www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/email-signup

Topical corticosteroids: steroid withdrawal reactions

Topical steroid withdrawal reactions have been reported in some long-term users of topical corticosteroids after they stop use. This is a mixed group of symptoms or conditions, often also referred to by patients as 'red skin syndrome' or 'topical steroid addiction'. A particularly severe type of topical steroid withdrawal reaction, with skin redness and burning worse than the original condition, is currently an under-recognised side effect of topical corticosteroid treatment.

Topical steroid withdrawal reactions are thought to occur after prolonged, frequent, or inappropriate use of moderate to high potency topical corticosteroids. **Topical steroid withdrawal reactions can develop after application of a topical corticosteroid at least daily for longer than a year. In children they can occur within as little as 2 months of daily use**. People with atopic dermatitis are thought to be most at risk of developing topical steroid withdrawal reactions. It has been reported that the signs and symptoms occur within days to weeks after discontinuation of long-term topical corticosteroid treatment. They are most commonly seen after treatment of sensitive areas such as the face or genitals.

A leaflet for patients is available when clinicians are discussing the risks of treatment with topical corticosteroid and withdrawal reactions.

Prescribers are reminded:

- When prescribing a topical corticosteroid, consider the lowest potency needed.
- Advise patients on the amount of product to be applied; underuse can prolong treatment duration.
- Inform patients how long they should use a topical corticosteroid, especially on sensitive areas such as the face and genitals.
- Inform patients to return for medical advice if their skin condition worsens while using topical corticosteroid, and advise them when it would be appropriate to re-treat without a consultation.
- For patients currently on long-term topical corticosteroid treatment, consider reducing potency or frequency of application (or both)
- Be vigilant for the signs and symptoms of topical steroid withdrawal reactions.

See the Sep 2021 Drug Safety Update for further information.

Desogestrel-containing contraceptive pills

In July 2021, the MHRA agreed to reclassify two desogestrel-containing progestogen-only oral contraceptives (Hana® 75 microgram, Lovima® 75 microgram) from prescription-only (POM) to pharmacy (P) products for the prevention of pregnancy in women of childbearing age.

Additionally, Scottish Pharmacies from early November will be able to provide a 3 month supply (maximum of 6 months) of desogestrel 75 mg tablets as ***Bridging Contraception,*** either following an emergency hormonal contraception consultation or as a standalone temporary supply until a patient has seen their GP or sexual health service for a longer-term solution.

RPS Competency Framework for all Prescribers updated

The Royal Pharmaceutical Society (RPS) has published an updated competency framework for prescribers across professions, updating the 10 competencies across the consultation and prescribing governance domains. There is a focus on standardising guidance across professional boundaries.

Additional Steroid Emergency Card for Scotland

Healthcare Improvement Scotland (HIS) have launched a new additional Steroid Emergency Card for Scotland.

ADTC are currently consulting stakeholders and local advice and guidance on implementation will be issued in due course.

Contact Information:
General Primary Care Prescribing Advice:
Contact your Primary Care Pharmacist; or alternatively
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Email: FV.prescribingsupport@nhs.scot

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