Derbyshire Medicines Management Newsletter

www.derbyshiremedicinesmanagement.nhs.uk

Volume 8 Issue 2 **May 2018**

The purpose of the Medicines Management newsletter is to deliver succinct, evidence-based advice and information on primary care prescribing issues. Aimed at busy prescribers wanting to know key messages from the many publications in the previous month.

1. Round up of What's in the news

Emollient bath additives for the treatment of childhood eczema (BATHE): multicentre pragmatic parallel group randomised Controlled trial of clinical and cost effectiveness.

Santer M, Ridd MJ, Francis NA, Stuart B, Rumsby K, at al. BMJ 2018;361:k1332
https://www.bmj.com/bmj/section-pdf/976560?path=/bmj/361/8151/Research_Update.full.pdf

The objective of the trial was to determine the clinical effectiveness and cost effectiveness of including emollient bath additives in the management of eczema in children. This was a randomised open label superiority trial involving 483 children (1-11 years). Children within the intervention group were prescribed emollient bath additives to be used regularly for 12 months. The control group were asked to use no bath additives for 12 months. Both groups continued with standard eczema management, including leave-on emollients and regular topical corticosteroids when required.

What this study adds

This large, pragmatic randomised controlled trial of children with eczema found no evidence of a clinically meaningful benefit from emollient bath additives, when used in addition to standard eczema management.

Locally JAPC reviewed the evidence for bath and shower emollients in 2016 and classified these medicines as BLACK – not recommended for prescribing. This current trial supports the local position.

Chronic obstructive pulmonary disease: beclometasone, formoterol and glycopyrronium (Trimbow)

Evidence summary Published: 3 May 2018. nice.org.uk/guidance/es17

Recently we have seen the emergence of 2 triple combination inhalers, licenced for use in COPD. The NICE guideline on COPD recommends that triple therapy should be considered in people who remain breathless or have exacerbations despite using an ICS/LABA (add a LAMA) or a LAMA (add an ICS/LABA), irrespective of FEV1.

This evidence summary reviews the safety and efficacy of beclometasone/formoterol/glycopyrronium (Trimbow) in people with COPD.

Overall, the studies found small, statistically significant improvements in lung function, rates of moderate-to-severe exacerbations of COPD and health-related quality-of-life scores with beclometasone/formoterol/glycopyrronium compared with beclometasone/formoterol or indacaterol/glycopyrronium dual therapy, or tiotropium alone. The improvements may be of limited clinical importance.

In TRILOGY and TRINITY studies, improvements in primary outcomes relating to lung function and exacerbation rates just reached the level considered to be clinically important. For example, triple therapy with beclometasone/formoterol/glycopyrronium improved: pre-dose forced expiratory volume in 1 second (FEV1) by 0.081 litre more than dual therapy with beclometasone/formoterol over 26 weeks, and the rate of moderate-to-severe exacerbations by 0.1 exacerbation per year compared with tiotropium over 52 weeks.

In TRIBUTE, the rate of moderate-to-severe exacerbations was reduced with beclometasone/formoterol/glycopyrronium compared with indacaterol/glycopyrronium. However, although the difference between the groups was statistically significant, it did not reach the level considered to be clinically important. There were few significant differences between the treatment groups for other outcomes in this study.

Beclometasone/formoterol/glycopyrronium may be suitable for ***some people*** with moderate-to severe COPD who have found triple therapy beneficial using more than 1 inhaler and can use a pressurised metered dose inhaler (with or without a spacer), but who have difficulty using multiple inhalers. Triple therapy in a single inhaler may be preferable for people who have difficulty using more than 1 device or who find their medication regimen difficult or confusing, and have trouble complying with treatment. However, a single inhaler lacks flexibility and makes it difficult to amend the individual medicines if treatment needs changing for any reason. However a triple therapy combination inhaler will only attract a single prescription charge compared to 2 or 3 prescription charges for individual inhalers.

JAPC traffic light classification for Trimbow is BROWN - Triple therapy is reserved for exceptional use in severe disease in the presence of persistent exacerbations despite other treatments. Use of this combination product is cheaper than using the separate components. Triple therapy is reserved for exceptional use only. The London Respiratory Network reviewed the cost effectiveness of COPD interventions and have calculated the quality adjusted life years for triple therapy ranges from £35,000 to £130,000, rendering triple therapy as the least cost effective intervention.

Different durations of corticosteroid therapy for exacerbations of chronic obstructive pulmonary disease.
Walters JA, Tan DJ, White CJ, et al. Cochrane Database Syst Rev. 2018 Mar 19; 3:CD006897. doi: 10.1002/14651858.CD006897.pub4. (Review) PMID: 29553157
Current guidelines recommend that patients with acute exacerbations of chronic obstructive pulmonary disease (COPD) should be treated with systemic corticosteroid for 7 to 14 days. Intermittent systemic corticosteroid use is cumulatively associated with adverse effects such as osteoporosis, hyperglycaemia and muscle weakness. Shorter treatment could reduce adverse effects. The aim of the study was to compare different durations of systemic corticosteroid defined as short (i.e. seven or fewer days) or longer (i.e. longer than seven days). Results demonstrated that five days of oral corticosteroids is likely to be sufficient for treatment of adults with acute exacerbations of COPD, and this review suggests that the likelihood is low that shorter courses of systemic corticosteroids (of around five days) lead to worse outcomes than are seen with longer (10 to 14 days) courses. The authors do allude to the fact that the studies in this review did not include people with mild or moderate COPD; further studies comparing short-duration systemic corticosteroid versus conventional longer-duration systemic corticosteroid for treatment of adults with acute exacerbations of COPD are required.

Current local COPD guidance recommends 7-14 days for an oral corticosteroid for managing COPD exacerbations.

Hospital admissions for bleeding events associated with treatment with apixaban, dabigatran and rivaroxaban
Garbayo JL, Cañada MK, Isabel Pérez Castelló, Soler MT, Ribis MP. European J of Hospital Pharmacy.2017
http://dx.doi.org/10.1136/ejhpharm-2017-001390

This retrospective observational study analysed the hospital admissions for bleeding events associated with treatment with direct oral anticoagulants (DOACs) - apixaban, dabigatran and rivaroxaban from April 2015 through December 2016.
From the results 37 hospitalisation episodes for DOAC-induced bleeding in 32 patients (15 received rivaroxaban, 9 apixaban and 8 dabigatran) were detected, representing an incidence rate of 3.44 per 100 person-years (95% CI 2.35 to 4.86). The most common bleeding site was gastrointestinal (27 cases, 73.0%). Intracranial bleeding was rare (three cases, 8.1%). Four patients (12.5%) were receiving DOACs at full doses and had a 'dose reduction indication'. The mean (SD) length of stay was 8.4 (5.2) days. Three patients (8.1%) died during the hospitalisation. Among bleeding episodes without fatal outcome, DOACs were stopped in 14 cases, continued in 14 cases, switched for another DOAC in two cases and the dose was reduced in four cases.
The study concluded that DOACs are associated with serious bleeding events that require hospitalisation. A risk/benefit ratio assessment considering patient preferences and an individualised follow-up, especially in patients who are elderly, polymedicated or have impaired renal function, can help to reinforce the safe use of DOACs.

SGLT-2 inhibitors cut risk of death in diabetics
AstraZeneca announced results from a new analysis of its landmark CVD-REAL study, the first large real-world evidence study of its kind evaluating the risk of all-cause death (ACD), hospitalisation for heart failure (hHF), heart attack (myocardial infarction or MI) and stroke in patients with type-2 diabetes (T2D) receiving treatment with SGLT-2 inhibitors (SGLT-2i), including dapagliflozin versus other glucose-lowering medicines.
The new analysis (CVD-REAL 2) assessed data from more than 400,000 patients across six countries (Australia, Canada, Israel, Japan, Singapore and South Korea), 74% of whom did not have a history of established cardiovascular (CV) disease. Results showed that across this broad population of patients with T2D, treatment with an SGLT-2i (dapagliflozin, empagliflozin, canagliflozin, ipragliflozin, tofogliflozin or luseogliflozin) was associated with a 49% lower risk of all-cause death, 36% of hospitalisation for heart failure, 19% of MI and 32% of stroke ($p \leq 0.001$ for all) compared to other T2D medicines. There was also a 40% lower risk of the composite endpoint of hospitalisation for heart failure or all-cause death ($p<0.001$).

Canagliflozin and Heart Failure in Type 2 Diabetes Mellitus: Results From the CANVAS Program (Canagliflozin Cardiovascular Assessment Study)
Circulation. 2018; 137:00–00. DOI: 10.1161/CIRCULATIONAHA.118.034222
The CANVAS Program (Canagliflozin Cardiovascular Assessment Study) reports the effects on heart failure and cardiovascular death overall, in those with and without a baseline history of heart failure, and in other participant subgroups.

The CANVAS enrolled 10 142 participants with type 2 diabetes mellitus and high cardiovascular risk. Participants were randomly assigned to canagliflozin or placebo and followed for a mean of 188 weeks. The primary end point for these analyses was adjudicated cardiovascular death or hospitalized heart failure.
Results demonstrate overall, cardiovascular death or hospitalized heart failure was reduced in those treated with canagliflozin compared with placebo (16.3 versus 20.8 per 1000 patient years; hazard ratio [HR], 0.78; 95% confidence interval [CI], 0.67–0.91), as was fatal or hospitalized heart failure (HR, 0.70; 95% CI, 0.55–0.89) and hospitalized heart failure alone (HR, 0.67; 95% CI, 0.52–0.87). The benefit on cardiovascular death or hospitalized heart failure may be greater in patients with a prior history of heart failure (HR, 0.61; 95% CI, 0.46–0.80) compared with those without heart failure at baseline (HR, 0.87; 95% CI, 0.72–1.06; P interaction =0.021).
The authors conclude in patients with type 2 diabetes mellitus and an elevated risk of cardiovascular disease, canagliflozin reduced the risk of cardiovascular death or hospitalized heart failure across a broad range of different patient subgroups. Benefits may be greater in those with a history of heart failure at baseline.

(The EMPA-REG OUTCOME and the CANVAS trials, two recent large placebo controlled randomized trials of SGLT2 inhibitors (empagliflozin and canagliflozin, respectively) showed a 35% and a 33% reduced risk of admission to hospital for heart failure in addition to a 14% reduced risk of the prespecified primary composite cardiovascular outcome (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke))

Deleted products 2018 | MIMS online for April 2018

Anacal (heparinoid)	Capozide (captopril/hydrochlorothiazide)	Opizone (naltrexone)
Anacal Suppositories (heparinoid)	Choragon (chorionic gonadotrophin)	Resperate
Betesil (betamethasone)	Hexopal (inositol nicotinate)	Testim (testosterone)
Capoten (captopril)	Hexopal Forte (inositol nicotinate)	Videx (didanosine)

2. Drug safety update primarily relating to primary care prescribing
(For more information see Drug Safety Update) Volume 11 Issue 9 April 2018

Valproate medicines (Epilim▼, Depakote▼): contraindicated in women and girls of childbearing potential unless conditions of Pregnancy Prevention Programme are met.
Valproate medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme is in place. Ensure all women and girls (and their parent, caregiver, or responsible person, if necessary) are fully informed of the risks and the need to avoid exposure to valproate medicines in pregnancy.

Advice for healthcare professionals:
New contraindication unless Pregnancy Prevention Programme in place

- Valproate medicines must not be used in women and girls of childbearing potential unless the conditions of the Pregnancy Prevention Programme are met (see below) and only if other treatments are ineffective or not tolerated, as judged by an experienced specialist
- Prescribers will receive materials by post in the coming weeks to use in the implementation of the Pregnancy Prevention Programme (Patient Guide, Healthcare Professional Guide, Risk Acknowledgement Form, and, for pharmacists, Patient Cards and stickers to attach a warning label to the pack)
- GPs must identify and recall all women and girls who may be of childbearing potential, provide the Patient Guide and check they have been reviewed by a specialist in the last year and are on highly effective contraception (see DSU for information on contraception)
- Specialists must book in review appointments at least annually with women and girls under the Pregnancy Prevention Programme and re-evaluate treatment as necessary; explain clearly the conditions as outlined in the supporting materials; and complete and sign the Risk Acknowledgement Form—copies of the form must be given to the patient or patient/caregiver/responsible person and sent to their GP

Action for pharmacists

- Ensure valproate medicines are dispensed in whole packs whenever possible — all packs dispensed to women and girls of childbearing potential should have a warning label either on the carton or via a sticker (see later for more about warnings added to packs)
- Discuss risks in pregnancy with female patients each time you dispense valproate medicines and ensure they have the patient guide and have seen their GP or specialist to discuss their treatment and the need for contraception

Contraindication in pregnancy

- Use of valproate medicines in pregnancy is contraindicated for bipolar disorder and must only be considered for epilepsy if there is no suitable alternative treatment.

Act on and report any concerns about adverse pregnancy outcomes

- Report any suspected adverse reactions associated with valproate, including adverse pregnancy outcomes, via the Yellow Card Scheme

Conditions and guidance for the Pregnancy Prevention Programme
All women and girls of childbearing potential being treated with valproate medicines must be supported on a Pregnancy Prevention Programme. These conditions are also applicable to female patients who are not sexually active unless the prescriber considers that there are compelling reasons to indicate that there is no risk of pregnancy.

The Pregnancy Prevention Programme is a system of ensuring all female patients taking valproate medicines:

- have been told and understand the risks of use in pregnancy and have signed a Risk Acknowledgement Form
- are on highly effective contraception if necessary
- see their specialist at least every year

Conditions of the Pregnancy Prevention Programme for valproate are consistent with programmes available for other highly teratogenic drugs such as thalidomide and isotretinoin. For further details see the full drug safety update.

All local guidance and formularies have been updated with this advice. JAPC will review its decision again after the publication of literature.

Information from NHS England and NHS Improvement – learning from Coroners case and Regulation 28 report to prevent future deaths: Benzodiazepines and suicide
Background information regarding the case:
A patient with a long history of depression and anxiety received various different medicines including lorazepam. The lorazepam was prescribed over a period of 18 months, after which attempts were made to reduce the use of this drug. Although not taking lorazepam at the time of death, the patient's consultant psychiatrist believes that the patient was suffering from a withdrawal state following benzodiazepine use, which then contributed to anxiety and agitation as well as experiencing somatic symptoms. Sadly, the patient took their own life while suffering from a depressive disorder and effects of withdrawal from benzodiazepines. The long-term use of lorazepam (short-acting benzodiazepine) was found to be a contributory factor in this patient's death.

Samantha Travis, Controlled Drugs Accountable Officer at NHS England (North Midlands) has requested that the following information be shared with Primary Care prescribers as highlighted by the coroners case and detailed in the British Association for Psychopharmacology (BAP) comment paper, 'Benzodiazepines: Risks and benefits. A reconsideration' published in the Journal of Psychopharmacology (2013: 27(11) 967–971) https://www.bap.org.uk/docdetails.php?docID=77 .

Key messages for Primary care prescribers:

- All patients who are receiving benzodiazepines for extended periods of time should be reviewed by their prescribers on a regular basis so that their suitability for long term prescribing can be assessed. In particular, attention should be paid to the relative risks of short and long acting benzodiazepines.
- Guidance from the BAP reminds prescribers that they should always consider the potential for dependence or other harmful effects when prescribing benzodiazepines. Guidance recognises the importance of balancing the risks of dependence associated with long term use with the benefits of short or intermittent courses and the risks associated with the underlying condition for which treatment is being provided.
- Although short or intermittent use of benzodiazepines would usually be considered to be best practice, the BAP guidance accepts that for a minority of patients longer term treatment may be appropriate. However, in all cases vigilance of potential hazards is required throughout the course of treatment.
- Whilst the risks associated with benzodiazepine have been well known for many years, we are seeking your help in ensuring that all prescribers and pharmacists are reminded of the need for vigilance when prescribing these medicines.

Further information about advice on best practice in the management of benzodiazepine withdrawal is available through the National Institute of Health and Care Excellence (NICE) series of clinical knowledge summaries (CKS):
https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal#!scenario

Local DHcFT guideline also includes the following :
- Unless there are clear risks of more severe problems developing if benzodiazepines are stopped, patients should be encouraged to withdraw gradually after long term use.
- Decisions should be made in conjunction with the patient and their carers, where appropriate.
- May not be possible to stop and a decision to continue may be made as long as the patient periodically tries to slowly reduce with a goal of eventually stopping.
- Review frequently and reassess progress and risks.
- The chances of success are improved when the patients circumstances, psychiatrically, psychologically and socially are stable.

3. Local news and GP/pharmacist queries

Query from GP practice:
GP wants to prescribe mefenamic acid for a patient with dysmenorrhoea, but has noticed local BLACK traffic light classification. Why has mefenamic acid received this classification?

Answer:
Mefenamic acid was classified as BLACK (Dec 2017) by JAPC.
There is no evidence that mefenamic acid is more effective than other NSAIDs. It has a narrow therapeutic window, which increases the risk of accidental overdose, and is more likely than other NSAIDs to cause seizures in overdose.

A discussion of the evidence is outlined as follows: -

Mefenamic acid is indicated for use in mild to moderate pain, including dysmenorrhoea, and menorrhagia. Ibuprofen and naproxen are licensed for use in menorrhagia, but not dysmenorrhoea.

Dysmenorrhoea.
A Cochrane review examined the efficacy of NSAIDs versus paracetamol and placebo in dysmenorrhoea management[1]. All NSAIDs demonstrated superiority over placebo. Ibuprofen and naproxen were more effective than paracetamol. Trial numbers comparing NSAIDs head to head were too underpowered to draw meaningful conclusions.

NICE guidance on dysmenorrhoea [CG44 (2007): Heavy menstrual bleeding] does not recommend a specific NSAID. A levonorgestrel-releasing IUD should be offered in preference to an NSAID, tranexamic acid (TXA), or a combined oral contraceptive (COC).[2]

Menorrhagia
A Cochrane review which examined the efficacy of NSAIDs (ibuprofen, naproxen and mefenamic acid) and other interventions in menorrhagia, found no significant difference between mefenamic acid and naproxen, or between NSAIDs and oral contraceptives, despite small trial numbers.[3]

The Clinical Knowledge Summary (CKS) on menorrhagia[4] advises the following: -
- Naproxen — 500 mg as the first dose, then 250 mg every 6–8 hours.
- Ibuprofen — 400 mg three or four times daily.
- Mefenamic acid — 500 mg three times daily.

Treatment should start on day 1, and continue until bleeding stops, or symptoms improve. Stop the NSAID if symptoms don't improve at 3 months.

Safety
Mefenamic acid has a high potential for toxicity[5]. While the usual dose (and also the maximum) is 500mg three times daily. Ingesting a dose of 40mg/kg or more is considered toxic. A 50kg woman prescribed 500mg TDS of mefenamic acid would be at risk from taking an extra 500mg dose. Moderate to severe toxicity can manifest as seizures, metabolic acidosis, renal failure and coma.

Toxicity in overdose is especially relevant as prescribing of NSAIDs for menstrual problems is common for younger women, a demographic group in which self-harm, including drug overdose, is also prevalent. Given this risk profile of mefenamic acid after overdose, prescribing of this drug to groups at risk of self-harm should be avoided.

Conclusion
There is no convincing evidence that mefenamic acid is more effective for dysmenorrhoea or menorrhagia than other NSAIDs and it is more toxic in overdose and given the evidence (and cost of mefenamic acid) it would seem reasonable to choose other NSAIDs wherever possible, and to avoid use of mefenamic acid.

References
1. Marjoribanks J et al. Nonsteroidal anti-inflammatory drugs for dysmenorrhoea (Review). Cochrane Database Syst Rev;2010.
2. NICE. Clinical Guideline 44: Heavy Menstrual Bleeding, January 2007.
3. Lethaby A et al. Nonsteroidal anti-inflammatory drugs for heavy menstrual bleeding (Review). Cochrane Database Syst Rev;2013.
4. CKS. http://cks.nice.org.uk/ Accessed 17/4/2018
5. RDTC (Regional Drugs and Therapeutics Centre); Safer Medication Use- Mefenamic Acid (Jan 2014)

Medicines safety incidents

Information from Well Pharmacy to CCGs and Primary Care: learning from serious incident involving urgent prescriptions sent from Primary Care prescribers to Community Pharmacies via the Electronic Prescription Service (EPS):

Background to serious incident:

Following a home visit from a GP, a patient was prescribed Amoxicillin 500mg capsules for a suspected chest infection. On his return to the surgery the GP issued a prescription electronically via the Electronic Prescription Service (EPS), which was received and downloaded in the community pharmacy (Well Pharmacy). The EPS token was then sent to print. It's unclear whether it did print however we do know it was never labelled. This meant that the visual alert on the PMR which would indicate that the patient required a delivery was not seen by the pharmacy staff. There was no record of any verbal request from the GP, patient or the patient's family requesting this medication be delivered urgently. The medication was therefore never dispensed or supplied.

The patient collapsed 5 days later and was admitted to hospital. He sadly passed away three days later with the cause of death noted as sepsis. As the death was not expected the family referred the incident to the coroner as they wanted to understand how this happened so that steps could be taken to prevent anyone else being in the same situation.

Key learning points following investigation into this incident:

- Currently, the EPS system does not allow urgent prescriptions to be highlighted to the receiving pharmacy when sent from a GP system. This is independent of the pharmacy system supplier the pharmacy uses.
- Any notes on the prescription are not visible to the pharmacy until they print or open the prescription.
- Although the EPS system is very robust there are occasions when the system does not work as well as it should. This can be due to internet connection reliability and software or hardware failure which can result in prescriptions not being received or printed by the pharmacy.
- The EPS system alone cannot be solely relied upon to deliver important or urgent messages and prescriptions. All prescribers, clinicians and their teams must ensure these messages are conveyed directly to the receiving pharmacy by phone or face-to-face.
- NHS Digital will be responding nationally and undertaking work on the EPS system to make some improvements over the coming months.

Main message to Primary Care prescribers:

For prescriptions required to be urgently dispensed +/- delivered, requests need to be communicated directly to the community pharmacy.

Zuclopenthixol injection incident – incorrect formulation prescribed by GP practice & dispensed by Community Pharmacy; usually supplied & administered by mental health team:

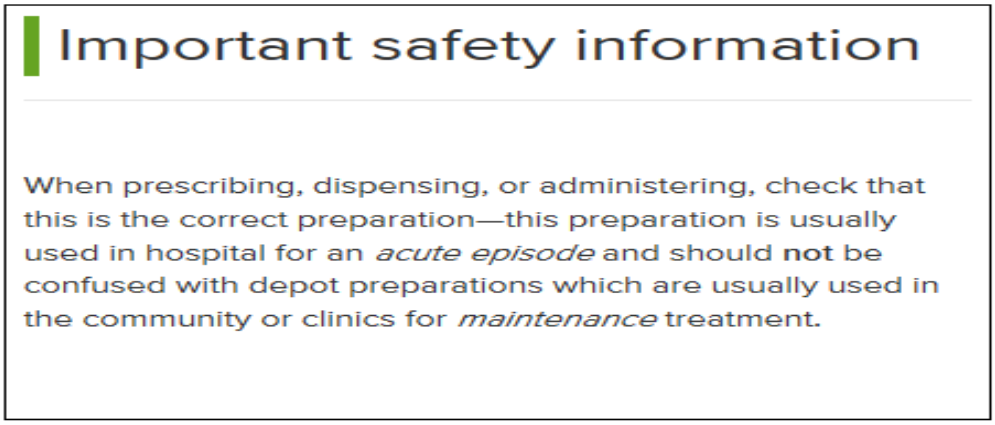
An incident has occurred locally whereby a patient was issued a prescription for Zuclopenthixol *acetate* 100mg/2ml injection by a GP practice on 2 separate occassions. This was also dispensed and supplied by the Community Pharmacy. The patient was actually on Zuclopenthixol *decanoate* (depot) injection, which was usually prescribed by the mental health team. This error was identified and reported by the Community Psychiatric Nurse (CPN) who usually adminsitered this medication to the patient every 2 weeks (at a dose of 600mg).

Upon further investigation of the incident, the following information was gathered:

i. The Zuclopenthixol injection was originally added incorrectly to the GP-held patient record as the *acetate* formulation on the repeat section of the record on the back of correspondence from the mental health team (formulation not specified on letter).
ii. The repeat prescription in the GP-held patient record stated 'DO NOT ISSUE' and appears not to have been issued until recently when the incident had come to light.
iii. A new non-medical prescriber (NMP) had started at the GP practice who had issued the Zuclopenthixol prescription alongside all other repeat medicines for the patient.
iv. The Community Pharmacy dispensed the Zuclopenthixol acetate injection despite the prescription being marked with 'DO NOT ISSUE' and this formulation mainly being used in a hospital setting.

Actions and learning following this incident:

i. The GP practice involved has now removed the Zuclopenthixol *acetate* from the repeat section of the GP-held patient record and put Zuclopenthixol *decanoate* as a 'Hospital Medication' within SystmOne. GP practice reminded of local guideline for recording medicines prescribed by other healthcare professionals.
ii. NMP involved made aware of the incident and involved in the investigation.
iii. Community Pharmacy have carried out their own internal investigations and reminded of the importance of being aware of different formulations of Zuclopenthixol injection and safety implications, as per advice in the BNF under 'Zuclopenthixol acetate':



iv. Incident also shared with medication safety officer at our local mental health trust (DHcFT) for information and with a request for correspondence to be made clearer for GP practices, where possible, regarding specific formulation of medication being prescribed i.e. instead of stating 'Zuclopenthixol' alone or 'Zuclopenthixol depot', which can be open to interpretation or misunderstanding.

The April 2018 edition of the North Midlands Controlled Drugs Newsletter can be found on the Derbyshire Medicines Management website.

4. Quality, Innovation, Productivity and Prevention (QIPP)

Classification of Movelat GEL as a rubefacient

Recent changes in the SPC for Movelat gel have seen the addition of the word non-steroidal to the mucopolysaccharide component and addition of the wording anti-inflammatory into the text. It is claimed that by adding these terms together, Movelat gel is classed as a NSAID.

PrescQIPP have reiterated that:

- The BNF does not list Movelat.
- Mucopolysaccharide polysulphate is not listed as an NSAID.
- The BNF states - NSAIDs reduce the production of prostaglandins by inhibiting the enzyme cyclo-oxygenase. They vary in their selectivity for inhibiting different types of cyclo-oxygenase; selective inhibition of cyclo-oxygenase-2 is associated with less gastro-intestinal intolerance.
- This is not how mucopolysaccharide polysulphate works.
- It's still got the same WHO classification as it had previously.

The local BLACK classification (not recommended) for all rubefacients including Movelat still remains.

April – price concessions

Prescribers should note that the re-imbursement price on FP10 may not necessarily reflect the Drug Tariff price as a result of a drug shortage. These concessionary prices are set by the Department of Health to reflect actual market prices.
A concession only lasts until the end of the month in which it was granted. If there is an on-going supply problem, it is possible that a new concession will be granted by the Department of Health the following month, however this is not guaranteed

Drug	Pack size	Price concession	Drug tariff price
Amitriptyline 50mg tablets	28	£2.88	£2.46
Aripiprazole 10mg tablets	28	£3.05	£1.99
Aripiprazole 5mg tablets	28	£2.85	£2.37
Aripiprazole 15mg tablets	28	£3.22	£2.75
Bicalutamide 150mg tablets	28	£16.94	£5.72
Bicalutamide 50mg tablets	28	£17.24	£2.20
Co-codamol 30mg/500mg capsules	100	£4.50	£3.88
Chlorpromazine 50mg tablets	28	£32.47	£28.09
Digoxin 125microgram tablets	28	£1.50	£1.22
Digoxin 250microgram tablets	28	£1.55	£1.22
Digoxin 62.5microgram tablets	28	£1.55	£1.23
Glimepiride 3mg tablets	30	£5.10	£3.65
Glimepiride 1mg tablets	30	£2.22	£1.63
Irbesartan 150mg tablets	28	£5.12	£1.08
Irbesartan 75mg tablets	28	£2.40	£0.80
Irbesartan 300mg tablets	28	£6.97	£1.77

Lacidipine 2mg tablets	28	£2.95	£2.71
Mirtazapine 30mg orodispersible tablets	30	£1.35	£1.17
Mirtazapine 15mg orodispersible tablets	30	£1.50	£1.00
Mirtazapine 45mg orodispersible tablets	30	£2.00	£1.68
Oxybutynin 5mg tablets	56	£1.87	£1.19
Oxybutynin 2.5mg tablets	56	£1.11	£0.84
Perindopril erbumine 2mg tablets	30	£4.13	£3.08
Perindopril erbumine 4mg tablets	30	£3.30	£1.91
Perindopril erbumine 8mg tablets	30	£5.85	£3.82
Pioglitazone 30mg tablets	28	£14.85	£0.92
Phenoxymethylpenicillin 125mg/5ml oral solution	100ml	£5.96	£4.97
Phenoxymethylpenicillin 250mg/5ml oral solution	100ml	£7.43	£7.34
Ramipril 2.5mg tablets	28	£1.04	£0.60
Topiramate 100mg tablets	60	£17.00	£2.29
Topiramate 50mg tablets	60	£9.50	£1.40
Trimethoprim 200mg tablets	6	£0.40	£0.31
Trimethoprim 50mg/5ml oral suspension sugar free	100ml	£3.75	£2.30
Venlafaxine 37.5mg tablets	56	£3.20	£1.97
Venlafaxine 75mg tablets	56	£5.68	£1.94

5. NICE summaries: New medicines (relating to primary care prescribing)

April 2018

NG95 – Lyme disease. This guideline covers diagnosing and managing Lyme disease. It aims to raise awareness of when Lyme disease should be suspected and ensure that people have prompt and consistent diagnosis and treatment. It does not cover preventing Lyme disease.

6. Useful resources

BMJ	www.thebmj.com
JAMA: The Journal of the American Medical Association	http://jama.ama-assn.org/
The Lancet	www.thelancet.com
The New England Journal of Medicine	http://content.nejm.org/
BMJ, JAMA and NEJM can be accessed in full-text directly through your NHS Athens Account via: National Library for Health: search via My Journals MyAthens: Via National Library for Health Resources or Local Resources. Current Lancet articles are sometimes available with free registration from http://www.thelancet.com/content/register. Print copies of The Lancet are available at DCGH library.	www.library.nhs.uk or www.athens.ac.uk
If you have not already registered for an NHS Athens Account, please register at: NB: It is recommended that you register on a Trust (NHS) PC for speedy confirmation of your username a password. Once registered, your account can be accessed from any computer with online access.	https://register.athensams.net/nhs/nhseng/
UKMI Nathnac NHS evidence Electronic medicines compendium Clinical Knowledge Summaries Medicines Prescribing Centre (Formerly NPC) Medicines for children (patient information leaflets Drugs in lactation	http://www.ukmi.nhs.uk/ https://www.evidence.nhs.uk/search?om=%5B%7B%22srn%22%3A%5B%22%20ukmi%20%22%5D%7D%5D http://www.nathnac.org/ http://www.evidence.nhs.uk/ http://www.medicines.org.uk/emc/ www.cks.nhs.uk. http://www.nice.org.uk/mpc/ http://www.medicinesforchildren.org.uk/ http://www.midlandsmedicines.nhs.uk/content.asp?section=6&subsection=17&pageIdx=1
UK teratology services	http://www.uktis.org/index.html
Vaccine update- Vaccination newsletter for health professionals and immunisation practitioners	https://www.gov.uk/government/organisations/public-health-england/series/vaccine-update