Medicines Safety Matters

A Newsletter from the Derbyshire and Nottinghamshire CCGs Medicines Safety Officers Network. Issue 10 December 2018

Welcome to our regular edition of Medicines Safety Matters; a newsletter produced by your local CCG Medicines Safety Officers. Our aim is to highlight to you medication incidents that have occurred both locally and nationally, thus promoting and supporting safer practice.

Key Messages in this Edition

- Colchicine toxicity
- Supply problems - EpiPen® & Epanutin® 30mg/5ml oral suspension
- Prescribing Insulin by brand - good practice guide
- PREVENT - Valproate pregnancy prevention programme
- PRoTeCT

Colchicine Toxicity

In a recent incident a patient was hospitalised following an incorrectly prescribed dose of colchicine to treat acute gout. Fortunately the patient recovered with no permanent harm.

Colchicine is an option to treat acute gout and may be preferred for patients who cannot take NSAIDs. However, colchicine has a narrow therapeutic index and is extremely toxic in overdose.

Lower doses should be considered for the elderly, patients with renal or hepatic impairment or patients weighing less than 50kg. Colchicine also has significant drug interactions with CYP3A4 inhibitors*, doses should be reduced by 50—75% or treatment may be contraindicated in patients with other risk factors for toxicity.

(*Common CYP3A4 inhibitors prescribed in primary care include diltiazem, verapamil, macrolide antibiotics and antifungals)

For acute gout the BNF recommends ONE tablet (500mcg) TWO to FOUR times daily until symptoms are relieved, maximum 12 tablets (6mg) per course and should not be repeated within THREE days. This may differ slightly from the product literature.

Patients should be counselled to ensure they take the correct dose and are aware to stop treatment straight away if they develop abdominal pain, nausea or vomiting. Consider limiting the prescribed quantity to 1 course - usually 12 tablets.

References

https://bnf.nice.org.uk/drug/colchicine.html#indicationsAndDoses

https://cks.nice.org.uk/gout

The British Society for Rheumatology Guideline for the Management of Gout https://academic.oup.com/rheumatology/article/56/7/e1/3855179

PREVENT - Valproate Pregnancy Prevention Programme

Following publication of the strengthened regulatory position on sodium valproate, Nottinghamshire CCG Medicines Management teams, in collaboration with relevant secondary care organisations, have developed guidance and resources to support the comprehensive and standardised implementation of the valproate pregnancy prevention programme. These are as follows:

- Standard Operating Procedure - The CCG medicines management team will be reviewing female patients under the age of 55 who are currently prescribed valproate on repeat.

In addition to the SOP the following resources are now available for prescribers to access via GP systems and F12:

- GP Consultation template embedded in SystmOne and Emis Web
- Risk prioritisation tables
- F12 referral templates

If you have any queries about any aspects of this work, please contact a member of your CCG medicines management team, who will be able to assist you.

Supply Problems

The following supply problems have been brought to our attention:

EpiPen® and EpiPen® Jr (adrenaline auto-injector devices) – Supply Disruption

EpiPen® and EpiPen® Jr will be subject to limited availability for the remainder of 2018. Mylan are now out of stock of EpiPen® Jr and interruptions in the supply are anticipated to continue for the coming months. (https://www.sps.nhs.uk/articles/shortage-of-epipen/).
To ease the current shortage of adrenaline auto injectors, ALK has extended the use of specific lot (batch) numbers of Jext® 150 mcg and Jext® 300 mcg auto-injectors, beyond the labelled expiry date by four months see 'Letter to Healthcare Professionals'

Epanutin® (phenytoin) 30mg/5ml Oral Suspension (Pfizer)

Temporary interruption of supply due to a global delay in manufacturing resulting in a possible out of stock period between 29th October and early December 2018.

Avoiding patient harm through the application of prescribing safety indicators in English general practices (PRoTeCT)

Locally, as part of the evaluation, PRoTeCT will be evaluating PINCER. The evaluation will be undertaken across 12-20 GP practices. GP practices will be contacted by the PRoTeCT team for help with obtaining patient interviews. Please support them.

Good Practice - Prescribe Insulins by Brand!

New insulin preparations have recently been made available for use in the UK, which means that more than one brand is now available for prescribing of Insulin Aspart and Insulin Lispro. Some of these insulins may have slightly different mechanisms of action or may be biosimilar insulins and may not be routinely interchangeable. Therefore, it is advised that insulins should be prescribed by brand to ensure that the patient receives the same/correct preparation each time it is prescribed and dispensed.

For example, currently, two different brands of Insulin Aspart are available on the market for prescribing and they are not interchangeable due to differences in the mechanism of action:

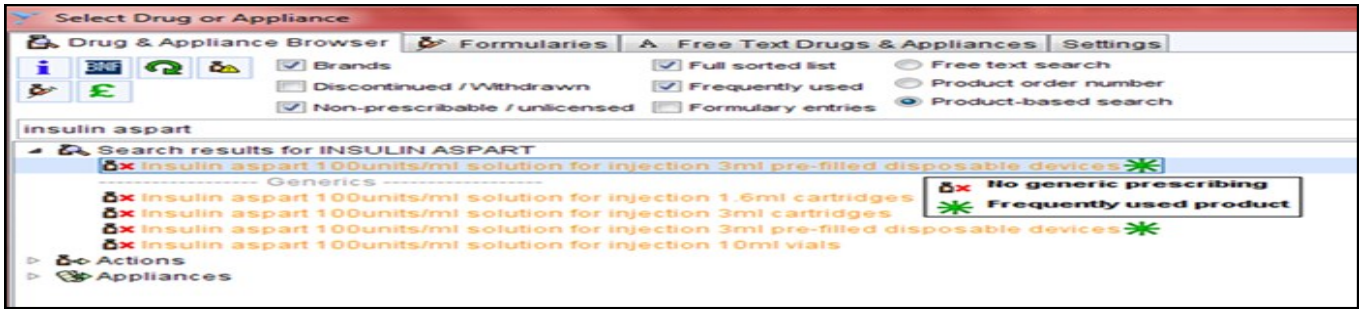
- NovoRapid®
- Fiasp®

There are subtle differences between the onset of action time and the timing of the injections, as shown in the table below.

	Timing of injection	Onset of action	Peak	Duration of action
Rapid-acting analogues				
Insulin aspart (**Fiasp**) (After specialist recommendation) *-an option for type 1 diabetes (NG17) in new adult patients*	Within 0-15 mins of meal	4 mins	1-3 hrs	3-5 hrs
Insulin aspart (**Novo Rapid**) *-an option for children and type 1 diabetes in patients already on treatment (NG17)*	Immediately before meal	10-20 mins	1-3 hrs.	3-5 hrs

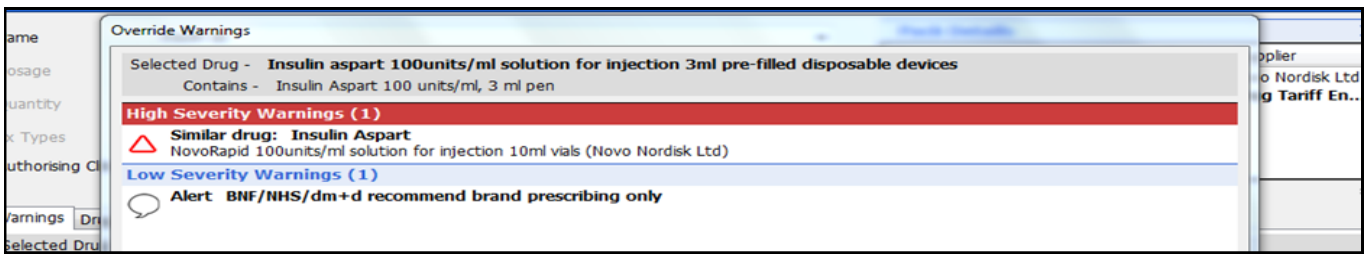
Another example includes different brands of Insulin Lispro – previously only the Humalog® brand has been available, but now a new brand called Insulin Lispro Sanofi® is also available for use and prescribing.

SystmOne screenshots – warning alerts in place to nudge prescriber to prescribe by brand for Insulin Aspart preparations:



EMIS screenshots – warning alerts in place to nudge prescriber to prescribe by brand

Alert message that appears when trying to prescribe Insulin Aspart generically:



Community Pharmacies are also reminded to follow advice in the BNF when dispensing and supplying all insulins: “Show container to patient or carer and confirm the expected version is dispensed”.