MedicinesUpdatePrimaryCare

NHS Greater Glasgow and Clyde

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Carbamazepine Chewtabs

Novartis are discontinuing supply of Tegretol® (carbamazepine) Chewtabs (100 mg and 200 mg). Based on current demand, supply of the 200 mg Chewtab tablet is expected to be depleted by end of October 2014 and the 100 mg Chewtab tablet by May 2015.

Novartis® has produced the following guidance for prescribers:

- "Novartis would advise that no new patients are initiated on Tegretol Chewtabs and that alternatives are sought for patients currently prescribed them.

- Abrupt withdrawal of Tegretol may precipitate seizures, therefore withdrawal should be gradual. If treatment with Tegretol Chewtabs has to be withdrawn abruptly in a patient with epilepsy, the changeover to another anti-epileptic drug should be performed under the cover of a suitable drug. Please refer to the SmPC for further safety information.

- Novartis is not in a position to be able to recommend alternative medications, as this would need to be a clinical decision based on the individual patient's medical history."

NHSGGC advice is that patients currently prescribed Tegretol Chewtabs should be changed to an alternative carbamazepine formulation, either:

1) Normal carbamazepine tablets (or sustained release). (For the treatment of epilepsy only – direction to the pharmacy to maintain the same manufacturer's product should be added to the dose instructions on the prescription) or
2) Carbamazepine liquid if the patient is unable to take tablets (For the treatment of epilepsy only – direction to the pharmacy to maintain the same manufacturer's product should be added to the dose instructions on the prescription)

Please contact your local epilepsy specialist if you require further advice.

Fluoxetine 10mg

We have noticed a recent increase in requests for fluoxetine 10mg tablets (unlicensed). The NHSGGC Unlicensed Medicines policy recommends unlicensed products should only be used where there is no suitable licensed alternative.

To achieve a 10mg dose of fluoxetine, prescribers may wish to consider prescribing 20mg capsules on alternate day dosing (fluoxetine has a long-half life of 4-6 days with the active metabolite half-life 4-16days). For patients in whom capsules are not suitable, licensed dispersible tablets which can be halved to give a 10mg dose would be the next most cost-effective alternative or fluoxetine liquid would provide a third less cost-effective alternative.

EMIS: Loss of interaction checking - acute methotrexate

The risk of a potentially fatal drug interaction between methotrexate and trimethoprim was highlighted in May's bulletin.

Acute prescriptions in EMIS PCS Scotland trigger clinical decision support (including interaction checks) while they are active and in Current View. These prescription records are moved into Past View automatically by the software once the course of treatment is complete or after 42 days if the course of treatment cannot be calculated. Recently it was identified that acute prescriptions for methotrexate tablets were being placed into Past View after only a few days rather than after the 42 days.

A fix has now been applied which corrects this problem and methotrexate tablets will now remain in Current View for the 42 days from the day they are issued.

The advice from NSS IT Solution Stewardship is that doses for methotrexate should only be chosen from the pre-defined National Patient

Safety Agency (NPSA) options when adding or changing these prescriptions in a patient's record to ensure that the default durations for checking are maintained. To ensure that all acute Scripts for Methotrexate are using the NPSA dosages, it is advised that all Acute Methotrexate scripts should be done as a fresh issue as an acute prescription rather than restarting and reissuing a previous Acute prescription for Methotrexate.

However if a local dosage description is used, it requires to have "0" as the Max Daily Quantity otherwise it risks ending this item early and preventing interaction warnings appearing.

Inhaler Devices

The NHSGGC Primary Care Adult Asthma and COPD Inhaler Device guideline review process has commenced which will include all new inhalers/indications as part of the review. It is hoped that this process will be completed by the Spring of 2015.

In the meantime, with regards to some of the new inhaler device products and indications, prescribers should consider the following before prescribing:

- whether any of the new products/indications have been included in the GGC Preferred List (and Total Formulary)
- For those products which are non-formulary, consideration should be given as to whether the new product(s) offer any advantage(s) for patients at an individual level over existing GGC Preferred List and Formulary choices
- the GGC Primary Care Adult Asthma and COPD Inhaler device Guides continue to be valid for use across GGC
- Cost

Drug Safety Update info: Interferon ADR

The MHRA's October Drug Safety Bulletin contains information on reports of thrombotic microangiopathy and risk of nephrotic syndrome linked to interferon beta treatment. Prescribers should be aware of these possible adverse effects in patients currently or previously treated with interferon beta.

Thrombotic microangiopathy is characterised by occlusive microvascular thrombosis and secondary haemolysis. It is the hallmark of haemolytic uraemic syndrome and thrombotic thrombocytopenic purpura. Early clinical features include thrombocytopenia, new onset hypertension, and impaired renal function. Laboratory findings suggestive of thrombotic microangiopathy include decreased platelet counts, increased serum lactate dehydrogenase, and schistocytes (red blood cell fragmentation) on a blood film. Thrombotic microangiopathy may occur weeks to years after starting interferon beta treatment. A European review is currently investigating whether the existing UK formulation of Rebif® has an increased risk compared to the old formulation. If thrombotic microangiopathy is diagnosed, treat promptly and stop interferon immediately.

Cases of nephrotic syndrome have also been reported during interferon beta treatment. Nephrotic syndrome may be due to various underlying nephropathies and is characterised by proteinuria, hypoalbuminaemia and oedema and may occur weeks to years after starting treatment. If diagnosed, treat promptly and consider stopping interferon.

Changes to Dexamethasone Injection Strength

The MHRA's latest Drug Safety Bulletin contains information on changes to dexamethasone 4mg/ml injection. Since last month, this product has now been replaced by a new formulation: Dexamethasone 3.8mg/ml solution for injection. The reformulation means changes in the concentration, storage (new product requires refrigeration), packaging and presentation.

NHSGGC palliative care specialists have advised that the 3.3mg/ml formulation is the preferred product and the electronic formulary will be amended accordingly. The 3.3mg/ml product is now the only product being supplied for use in the acute setting in NHSGGC.