Welcome to issue 43 of the Fife Prescribing Update - a bi-monthly newsletter aimed at all medical and non-medical prescribers across NHS Fife. I hope you enjoy reading the newsletter! This issue includes a supplement by the Pain Team (see page 3). If you have enquiries about the content or articles covered in this newsletter, please contact your Locality Pharmacist. Articles in this newsletter are for guidance only and appropriate medical information e.g. BNF, Summary of Product Characteristics etc. should be consulted before use. Similarly, if you do not wish to receive this newsletter or your contact details are incorrect; please drop a line to gilliankerr1@nhs.net.

The NHS Fife Contraceptive Prescribing Guidance was reviewed at the August ADTC and will subsequently be updated on the NHS Fife Formulary website. The COC of first choice is a 2nd generation pill containing levonorgestrel (i.e. Rigevidon®). The POP of first choice will be Cerelle® or Micronor®. The new brands are highlighted as Formulary choices in the eFormularies in EMIS and Vision prescribing systems.

**“NEW” BRANDS OF ORAL CONTRACEPTIVES WHICH ARE INCLUDED IN THE NHS FIFE FORMULARY**

<table>
<thead>
<tr>
<th>Preferred Formulary Choice</th>
<th>Equivalent to (non formulary)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rigevidon®</strong></td>
<td>Rigevdon® is the first line choice combined oral contraceptive (COC)</td>
</tr>
<tr>
<td><strong>Cerelle®</strong></td>
<td>Cerelle® is first line choice Progestogen only contraceptive (POP) along with Micronor®</td>
</tr>
<tr>
<td><strong>Gedarel 30®</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Millinette®</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gedarel 20®</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Millinette 20®</strong></td>
<td></td>
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</tbody>
</table>

These four are third line choices of COCs. There are no new brands in the second line choices which are Loestrin 30®, Loestrin 20® and Ovysmen® or Cilest®.

Established COC users may also be suitable for switching to one of the new approved COCs. Patients can be reassured that the newer products contain the same ingredients at the same dose, however packaging and colours of pills may differ from previous brands. They are more competitively priced and thus provide the potential for cost efficiencies.
**DRUG NAME CONFUSION**

**Medication Incident:**
Patient had been taking the wrong medication.

*A patient was prescribed Requip® XL 8mg(ropinirole m/r 8mg) but Reminyl® XL 8mg(galantamine m/r 8mg) had been dispensed.*

- **Action:** Medical staff, patient and pharmacy were informed. The correct medication was ordered. The side effects of the "wrong drug" (Reminyl) can worsen Parkinson's.

**Learning Point:**
Extreme care must be taken as life-threatening errors may occur if a *similarly named medicine* is dispensed or prescribed in error.

The MHRA warning concerning confusion between similarly named medicines was reported in the June 2013 Fife Prescribing update. (issue 42) See the MHRA article at: [http://www.mhra.gov.uk/home/groups/dsu/documents/publication/con267913.pdf](http://www.mhra.gov.uk/home/groups/dsu/documents/publication/con267913.pdf)

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**PGD Recording Requirements**

Following the recent audit of the use of PGDs across NHS Fife CHPs we would like to remind all practitioners that the following information MUST be recorded every time a patient is treated using a PGD:

- Date of treatment
- Name of Patient
- Name of medications
- Dose
- Route/site as applicable
- Name of manufacturer / brand
- Medication batch number & expiry date
- Name & signature/ individual log-in (for paper light areas) of clinician providing treatment

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**NHS Fife Formulary Abbreviated List**

An electronic version of the NHS Fife Abbreviated Formulary list is available from the link below. This can be saved to your PC or laptop or can be downloaded onto devices e.g. Smart phones, e-readers and tablets:


The abbreviated list includes the names of medicines specifically recommended as 1st and 2nd choices or those only approved for restricted use within NHS Fife and is structured in line with the BNF classification.

Healthcare professionals should ensure that they refer to the latest version of the abbreviated list. Updated versions will be circulated via Daily Dispatch and will also be available to be downloaded from the ADTC website at [www.fifeadtc.scot.nhs.uk/](http://www.fifeadtc.scot.nhs.uk/)

A full version of the NHS Fife Formulary which includes locally and nationally approved guidelines and further prescribing information can be accessed from the Fife ADTC website.

**Promoting compliance with formulary choices is one of the ways that NHS Fife can encourage the prescribing of the most cost-effective products for our patients.**

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**SAFETY ADVICE FOR PRESCRIBING STRONTIUM RANELATE (Protelos®)**

The NHS Fife prescribing advice for strontium ranelate (Protelos®) has been revised following the new safety advice from the MHRA. NHS Fife Bone Health and Falls Managed Clinical Network (MCN) recommend that all patients prescribed strontium are reviewed to assess the risk/benefit of remaining on strontium.

The letter and flow diagram for prescribing advice for strontium ranelate can be accessed from the following link:


The Fife Joint Formulary section 6.6.2 (Bisphosphonates & other drugs affecting bone metabolism) and the NHS Fife Guidance on diagnosis and management of osteoporosis will shortly be updated to reflect this change in advice.
Pharmacological Management of Chronic Non-Malignant Pain

Pain Management

Pain is very complex and requires a holistic approach to its management. Consider exercise, relaxation, pacing and self help techniques such as TENS, heat pads and cold packs. Please refer to [https://sites.google.com/site/fifepaininfo](https://sites.google.com/site/fifepaininfo) for further information, advice and patient leaflets on pain management.

The Fife Integrated Pain Management Service issued updated prescribing guidelines in August 2012. This newsletter has been written by Fife specialist pain pharmacists to summarise the key aspects of the pharmacological management of pain. Please refer to the full guidelines – Appendix 4C [http://www.fifeadtc.scot.nhs.uk](http://www.fifeadtc.scot.nhs.uk)

What medicines should be used and when?

Chronic pain may require a range of medications to be used concurrently. Patients do not always understand this or the types of pain their medications are being used to treat.

All medications used in the treatment of chronic pain require an adequate trial and review.

The Fife Integrated Pain Management Service promotes the use of the WHO pain ladder as a guide to the pharmacological management of Chronic Pain:

**WHO Pain Ladder**

<table>
<thead>
<tr>
<th>Step</th>
<th>Pain</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Mechanical Pain</td>
<td>Paracetamol +/- Inflammatory Pain (e.g. Ibuprofen)</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Inflammatory Pain</td>
<td>Anti-inflammatory (e.g. Ibuprofen) +/- Nerve Pain Adjuvant (e.g. Amitriptyline)</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Nerve Pain</td>
<td>Adjuvant (e.g. Amitriptyline)</td>
</tr>
</tbody>
</table>

**NSAIDs- Has the Evidence about Increased Risk of Cardiovascular Events changed your prescribing?**

After a recent Europe-wide review of cardiovascular safety, the MHRA letter of 4th July 2013 highlighted that diclofenac is now contraindicated in patients with established:

- Ischaemic heart disease
- Peripheral arterial disease
- Cerebrovascular disease
- Congestive heart failure (New York Heart Association [NYHA] classification II - IV)

Patients prescribed diclofenac with these conditions should be reviewed at their next routine appointment and changed to an alternative treatment if analgesia is required. The Fife formulary recommends the following:

- Consider simple analgesics instead such as paracetamol or co-codamol 30/500.
- If a NSAID is still considered to be essential, then Naproxen would be NSAID of choice.
- Diclofenac treatment should only be initiated after careful consideration for patients with significant risk factors for cardiovascular events (e.g. Hypertension, hyperlipidaemia, diabetes, mellitus, smoking).

**Use of strong opioids and patches - Are they being used appropriately?**

**Transdermal Opioids: Approximate equivalence with other opioids**

<table>
<thead>
<tr>
<th>Transdermal buprenorphine (mcg/hour)</th>
<th>5</th>
<th>10</th>
<th>20</th>
<th>35</th>
<th>52.5</th>
<th>70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transdermal fentanyl (mcg/hour)</td>
<td>12</td>
<td>25</td>
<td>50</td>
<td>75</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Oral morphine equivalent (mg/24 hours)</td>
<td>10</td>
<td>15</td>
<td>30</td>
<td>45</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>Tramadol equivalent (mg/24 hours)</td>
<td>50</td>
<td>150</td>
<td>300</td>
<td>400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine equivalent (mg/24 hours)</td>
<td>100mg</td>
<td>150mg - 240mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N.B. Published conversion ratios vary and these figures are a guide only. Dose equivalences are only approximate and prescribers should be very cautious when changing patients to alternative opioids. Patients may need to be withdrawn slowly from their opioid to prevent withdrawal effects. Patient response may be variable.
Use of strong opioids and patches - Are they being used appropriately?

Key Messages

1. Strong Opioids - General Points
   - Strong opioids are only justified if other drugs with less risk of side-effects have failed.
   - Patches should only be considered if oral route is inappropriate i.e. non-compliance, swallowing difficulties, dementia.
   - Patients should have a clear understanding of the risks associated with long-term use and realistic treatment goals.

FIFE GUIDANCE for NEUROPATHIC PAIN

Neuropathic pain can be described by patients using the following descriptors: sharp, stabbing, burning, tingling, pins and needles.

In order to assess if a patient has neuropathic pain the recommended assessment tool for neuropathic pain is the DN4 (See Fife Guidance for Chronic Pain appendix 4C)

First Line

Amitriptyline
   - Start with a low dose. Starting dose 10mg daily 10-12 hours before getting up the next day; titrating to 75mg or maximum tolerated dose. Taking the dose earlier in the evening can prevent “hangover” effect in the morning.
   - Avoid in ischaemic heart disease, cognitive impairment.
   - Review after 4 weeks; if no response, withdraw gradually.

Nortriptyline
   - Dose and cautions as above but less sedating and often less dry mouth than amitriptyline.

Second Line

Gabapentin
   - Consider first line if tricyclic contra-indicated.
   - Prescribe Capsules as they are more cost effective.
   - Starting dose is 300mg daily in the evening titrating to 600mg TDS (or to the maximum tolerated dose) for 4 weeks then assess response. Dose can be further increased to a maximum of 3.6g daily in 3 divided doses i.e. maximum of 1200mg three times a day.
   - Starting dose in the elderly or frail patients is 100mg daily in the evening.
   - Caution with dose titration in renal impairment - see appendix 4c.
   - Review after 4-6 weeks at maximum tolerated dose, if no response, withdraw gradually.
   - Caution if patient has a history of previous drug misuse due to potential for abuse.

3rd Line

Amitriptyline or Nortriptyline in combination with Gabapentin
   - May be tried together if inadequate response to either alone.

4th Line

Pregabalin
   - For use only if inadequate pain relief or not tolerated a Tricyclic or Gabapentin.
   - Prescribe as a twice a day dose as this is more cost efficient.
   - Use the correct strength as all strengths of the capsules are the same cost.
   - Initial dose is 75mg twice a day. Increase weekly to 300mg BD or maximum tolerated dose – see Appendix 4c.
   - Elderly, frail or those previously intolerant of gabapentin starting dose of pregabalin: 25mg twice a day.
   - Caution with dose titration in renal impairment - see appendix 4c.
   - Can be co-prescribed with Amtriptyline or Nortriptyline (usual max dose of Amitriptyline/ Nortriptyline in combination 50mg daily).
   - Must NOT be co-prescribed with Gabapentin.
   - Caution if history of previous drug misuse due to potential for abuse.

Review - If insufficient benefit after 8 weeks at maximum tolerated dose, discontinue gradually.

Tramadol
   - Consider if no response or poor tolerance to first or second choice, either with regular paracetamol, or in combination with the above.
   - May be particularly useful if patient has mixed pain aetiology.
   - Prescribe 50mg capsules; modified release preparations are expensive; only prescribe these if there is evidence of break-through pain.
   - Caution with hepatic and/or renal impairment and in the elderly.
   - Caution with co-prescribing with other serotonergic drugs e.g. SSRIs, triptans.
   - If no response after 4 weeks, discontinue gradually.

Capsaicin cream 0.025% - consider third line for localised nerve pain
   - Prescribe as TDS or QDS for a 4-6 week trial

For further advice on pain medication or pain management in general, please contact:
Fife Integrated Pain Management Service, Queen Margaret Hospital
Tel: 01383 623623 ext 20903  Email: Fife-UHB.RiversTeam@nhs.net