Basingstoke, Southampton and Winchester District Prescribing Committee

Recommendations of the meeting of 14th June 2011

Supported/Limited support

- **Atorvastatin 80mg in Acute Coronary Syndrome (ACS)-** Although it was accepted that a relatively small number of patients may require this dose following specialist recommendation, the limited tolerability was discussed as well as the length of treatment required after the last ACS episode. Further advice will follow. Atorvastatin loses it's patent protection in May 2012, after which time low cost generics are likely to be available. Local use of the lower cost first line generic statins remains at around 80-85% currently.

- **ACE Inhibitors and Angiotensin 2 receptor antagonists (A2RAs)** - Ramipril remains first line ACE inhibitor locally, with enalapril and captopril second line options and/or for use in secondary care. Lisinopril also remains a cost-effective second line option in primary care. Further advice will follow in due course on ACE Inhibitor induced cough. If an A2RA is required, then losartan is recommended. Candesartan provides another option. Dual therapy has a limited role in specialist settings and requires careful monitoring of renal function.

- **Denosumab Shared Care Guideline in Osteoporosis**- This was approved for local use, subject to minor amendments. The patient will be assessed by a specialist, and the first injection will be prescribed and administered in the specialist setting. The GP may then agree to take over prescribing of 6-monthly injections for up to 3 years. Other osteoporosis treatments such as bisphosphonates and strontium should be stopped in primary care, so good communication is essential. Calcium and Vitamin D supplements should normally continue.

Not Supported

- **Indacaterol Breezhaler in COPD-** This new 'LABA' medication for COPD is not recommended for use currently based on the limited evidence from one short trial that did not use patient orientated outcomes. This can be reviewed in due course when the results of further 'head to head' studies become available.

Information / Reminders / Safety Messages / NICE

- **Drug Treatment of Overactive Bladder- key messages for prescribers**
    1. In the absence of 'red flag' symptoms, the first priority for treatment in overactive bladder and most other forms of urinary incontinence is at least 3 months of bladder re-training. This includes pelvic floor muscle exercises, as well as other measures. Consider referral to continence advisory services for supervised re-training if available.
    2. If considering anti-muscarinic drug treatment, prescribe for a maximum of one month initially, on acute prescription, and review, alongside bladder re-training measures.
    3. If effective continue drug treatment for 3-6 months only and then review. Consider a 'drug holiday' for a couple of weeks, and if successful discontinue treatment. Some patients will be able to manage long term without medication with no further problems.
    4. NICE recommends oxybutynin as a first line option. If one anti-muscarinic is ineffective then stop and consider prescribing another second line anti-muscarinic, following NICE recommendations. If this is ineffective then consider onward referral to the local urology team.

- **Dabigatran in Atrial Fibrillation-** Dabigatran is a direct thrombin inhibitor currently licensed for the prevention of VTE post knee or hip replacement surgery. It is likely to receive a marketing authorisation for the prevention of stroke in patients with AF shortly, so there is interest among clinicians about its use as an alternative to warfarin. It will be more expensive than warfarin so potentially a significant financial pressure if all patients currently on warfarin were transferred without a corresponding disinvestment in INR monitoring services. The Priorities Committee issued a statement on this recently and its current recommendation is that dabigatran for the prevention of stroke and systemic embolism in AF is considered 'low priority'. NICE Guidance is expected in December 2011. Given the Priorities Committee statement the DPC agreed that clinicians would not be expected to routinely initiate or recommend this treatment at this stage. Obviously any widespread use of this agent needs prior agreement and disinvestment from current anticoagulation monitoring services.

- **Timolol preservative free eye drops 0.25%-** There is currently a supply problem with 0.25% unit dose supplies. The timolol 0.5% preservative free unit dose product remains available as an alternative. Also, betaxolol 0.25% unit dose eye drops provides a beta blocker alternative with a twice daily dosing schedule. Very few patients should be affected by the supply problem, but those that are will require review.

- **Change of dosing schedule for paracetamol in children-** Doses have recently changed with more age bands included. Medication packaging will take some time to reflect this. For further information please see http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON120251

Summarised on behalf of the District Prescribing Committee
Julia Bowey (NHS Southampton City) 22.06.11