# Prescribing Tips

ZIAD SULEIMAN – PHARMACIST PRACTITIONER (IP) CHURCHDOWN SURGERY

# Pharmacists in General Practice!

- Who has a clinical pharmacist in their practice?
- NHS pilot now becoming part of the new GP contract
- In 5 years every practice may have a pharmacist on the team, hopefully even a pharmacy technician.
- Managing medication
- Managing complex/multi-morbidity/polypharmacy patients

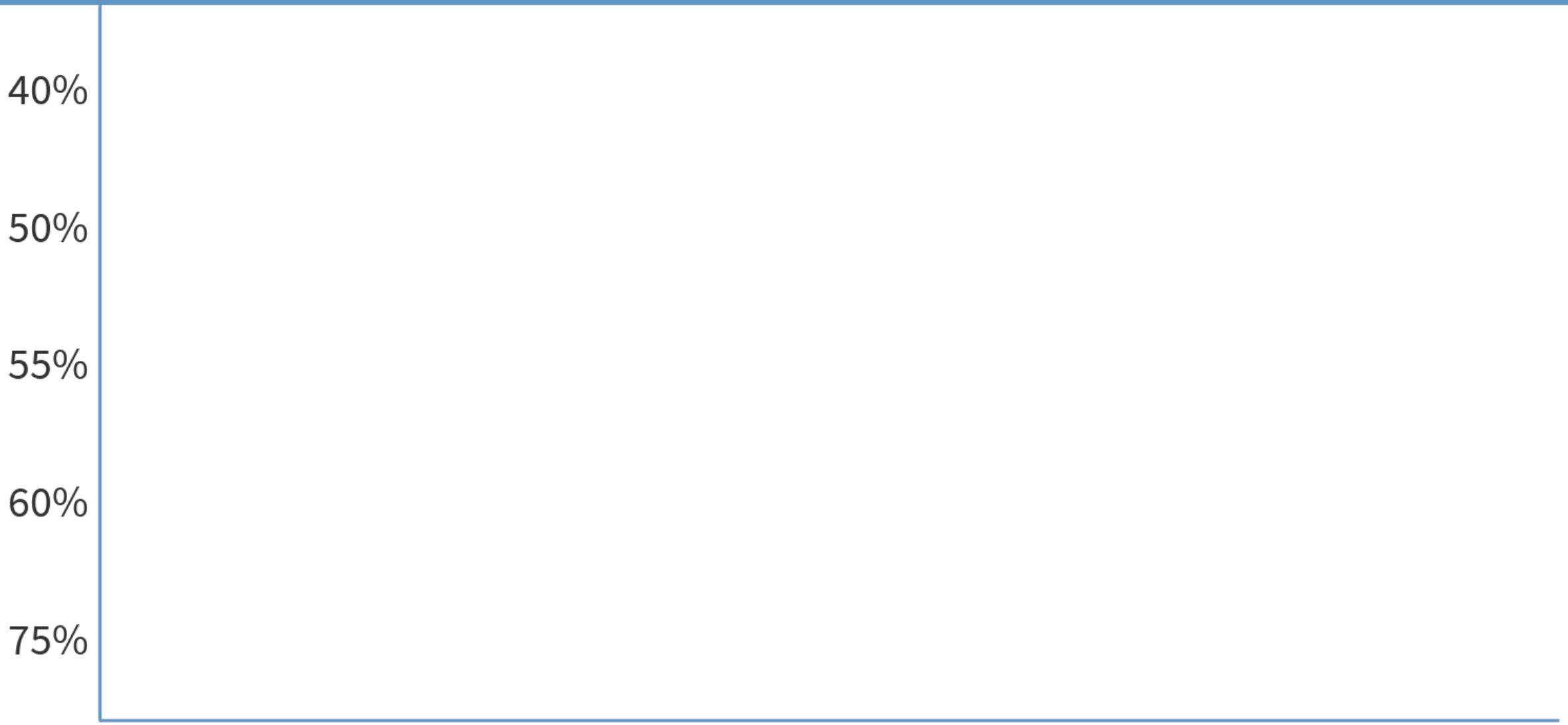
# Interactive answers

- Groups of 3 or 4
- One mobile phone per group
- One answer per group
- Log in now – **PollEv.com/movingpine869**

# Challenge

- “Medication without harm” WHO 2017
- Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally
- Life expectancy is increasing
- Multi-morbidity is increasing
- Polypharmacy – 4 or more medications!!

# What % of people on 4 or more medications are classed as 'adherent'?



# Challenge

- “Medication without harm” WHO 2017
- Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally
- Life expectancy is increasing
- Multi-morbidity is increasing
- Polypharmacy – 4 or more medications!! Adherence = 50%.
- Appropriate vs inappropriate polypharmacy

# Start carefully

- Don’t start a medication without an exit strategy
- Make the exit strategy clear for all to see – patient and clinicians
- Don’t start a medication without a clear indication
- Make the indication clear for all to see
- Do not start a new medication as a repeat prescription
- Review the patient! What happens if patient DNA’s?

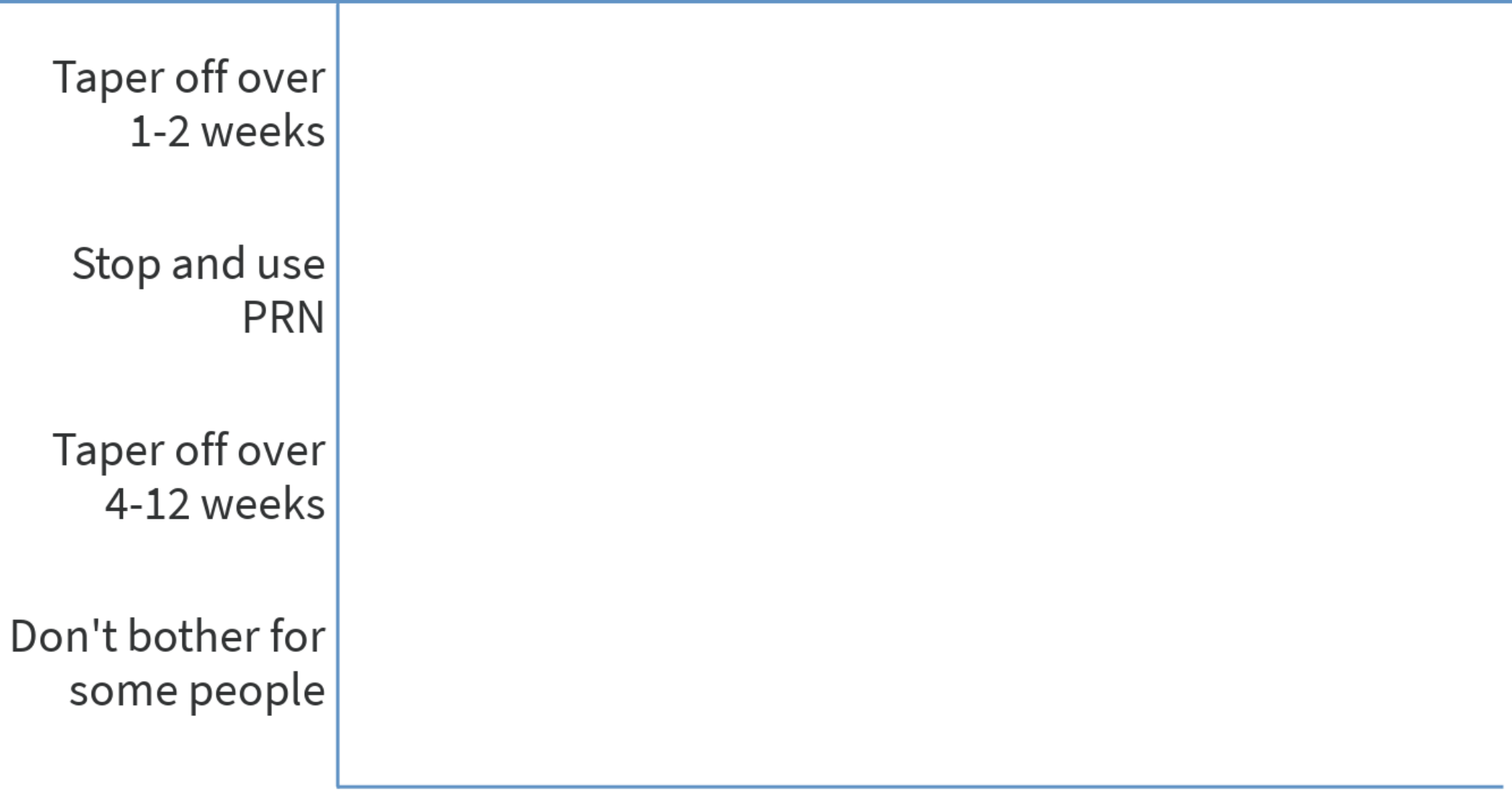
# PPI's

- What are the concerns?
  - Fractures
  - Infections (C.diff)
  - Dementia
  - CKD
  - CVD
  - Hypomagnesaemia
  - B12
  - Interactions
  - Can mask cancer

# PPI's in GORD

- Dyspepsia and GORD NICE guidance?
  - "Stepwise return to self-care"
- How to start?
  - 1 month full dose then review
- How to prescribe?
  - "Take ONE daily for 1 month for GORD then review" ACUTE 28 days
  - "Take ONE daily" REPEAT 28/56 days – How NOT to start!
- How to continue prescribing?
  - 'Take ONE daily for GORD – 6 monthly review" (or 3 month/annual)

# How would you 'deprescribe' PPIs?



# Deprescribing PPIs

- Why taking?
- Reduce dose – review at 4 and 12 weeks, then reduce/stop
- Lifestyle mods
- OTC remedies
- PRN use instead?

# DOACs

- What are the concerns?

# What are the main concerns with DOACs?

# DOACs

- What are the concerns?
  - Under-dosing
  - Over-dosing
  - Non-adherence
  - Risk of major bleeds
  - Combining with anti-platelets
  - Different dosing regimes for AF or DVT/PE

# DOACs

- How to dose?
- How to start?
- How to prescribe?
- How to continue prescribing?

# What do you need to know in order to correctly dose a DOAC in AF?

# DOACs

- How to dose?
  - Creatinine clearance! What about weight of patient? System calculator? MD Calc?
- How to start?
  - ASAP for AF – coag screen? 1 month then review. DOAC advice?
- How to prescribe?
  - "Take ONE daily for life" – AF
  - "Take ONE daily. Review August 2019" – DVT/PE
  - On antiplatelet - stop/continue/reduce DOAC?
- How to continue prescribing?
  - How often to review doses? Regular weight, serum creatinine.

# DOACs and antiplatelets

- No straight answer – each case is individual
- Cardiology should make this clear on discharge
- "The 2018 European Heart Rhythm Association Practical Guide on the use of non-vitamin K antagonist oral anticoagulants in patients with atrial fibrillation"
- Pt with AF already on DOAC has ACS – DAPT/triple therapy depends on type of stent and atherothrombotic risk
- Stable CAD patient >1yr post ACS develops AF – most patients can stop antiplatelet when starting DOAC

# DOAC advice?

- How to take! **Adherence**
- What to do if miss a dose?
- Interactions – macrolides, itraconazole, NSAIDs, enzyme inducers, St Johns Wort, SSRI/SNRI
- Surgery
- Bleeding and what to do
- Alcohol advice
- Info card to carry

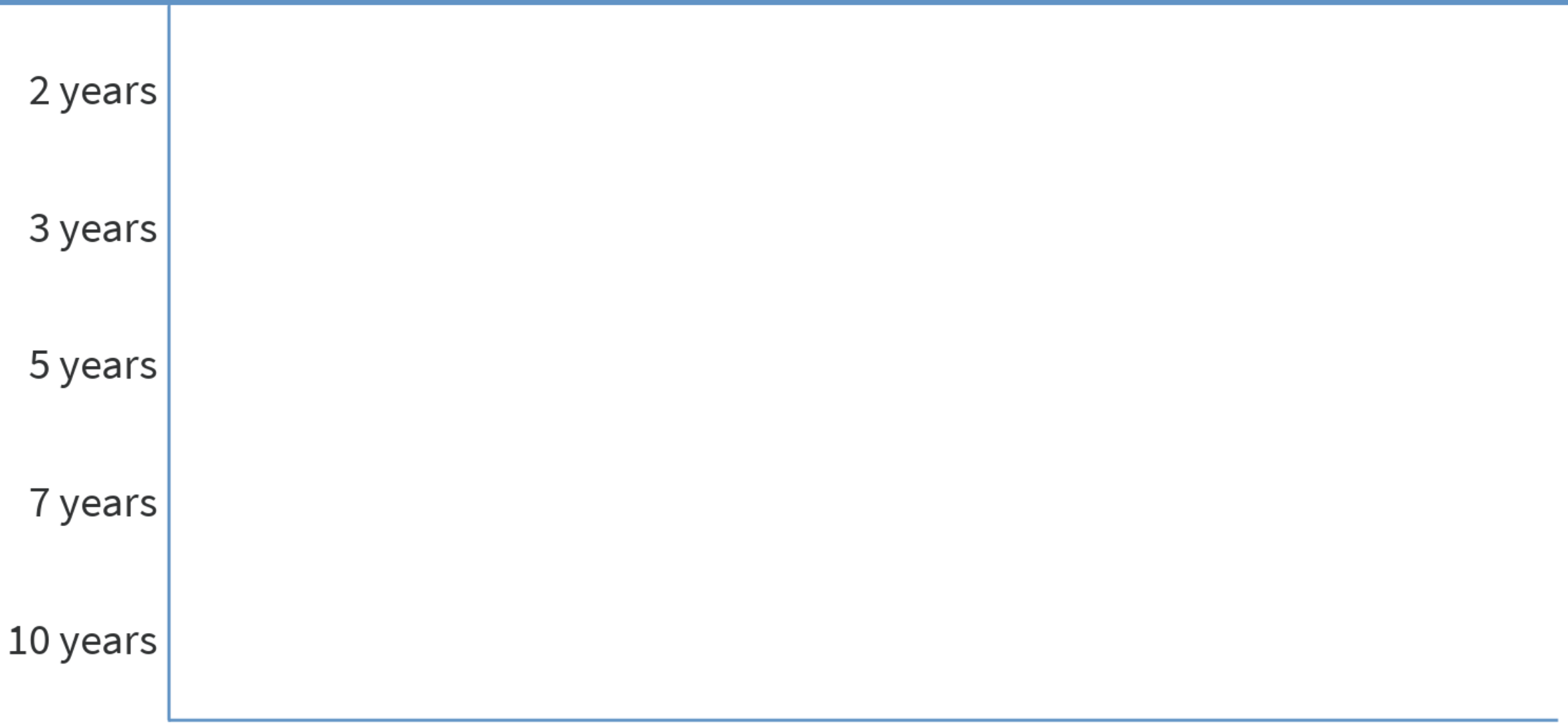
# Bisphosphonates

- What are the concerns?
  - Atypical fractures
  - ONJ and external ear canal
  - Oesophageal cancer
  - GI side-effects

# Bisphosphonates

- How to take?
  - First thing with full glass of water, no med/food/drink for 30 mins, upright for 30 mins.
- How to start?
  - Dental check? Explain may not be lifelong – treatment breaks.
- How to prescribe?
  - "Take ONE each week. Review in 2024".
  - Adherence check soon after starting and if any fracture on treatment.
- How to continue prescribing?
  - Decide how long should be on it for and how to review.

# How long before you consider a drug holiday for bisphosponates?



# Calcium and Vitamin D?

- If diagnosis of osteoporosis or on bisphosphonate then OK to prescribe on NHS.
- MUST be calcium replete to start and continue bisphosphonate.
- Do they need calcium if dietary intake is OK? Online calculator.
- Start bone meds if high risk/osteoporosis? Or lifestyle advice?
- NICE patient decision aid for bisphosphonates.

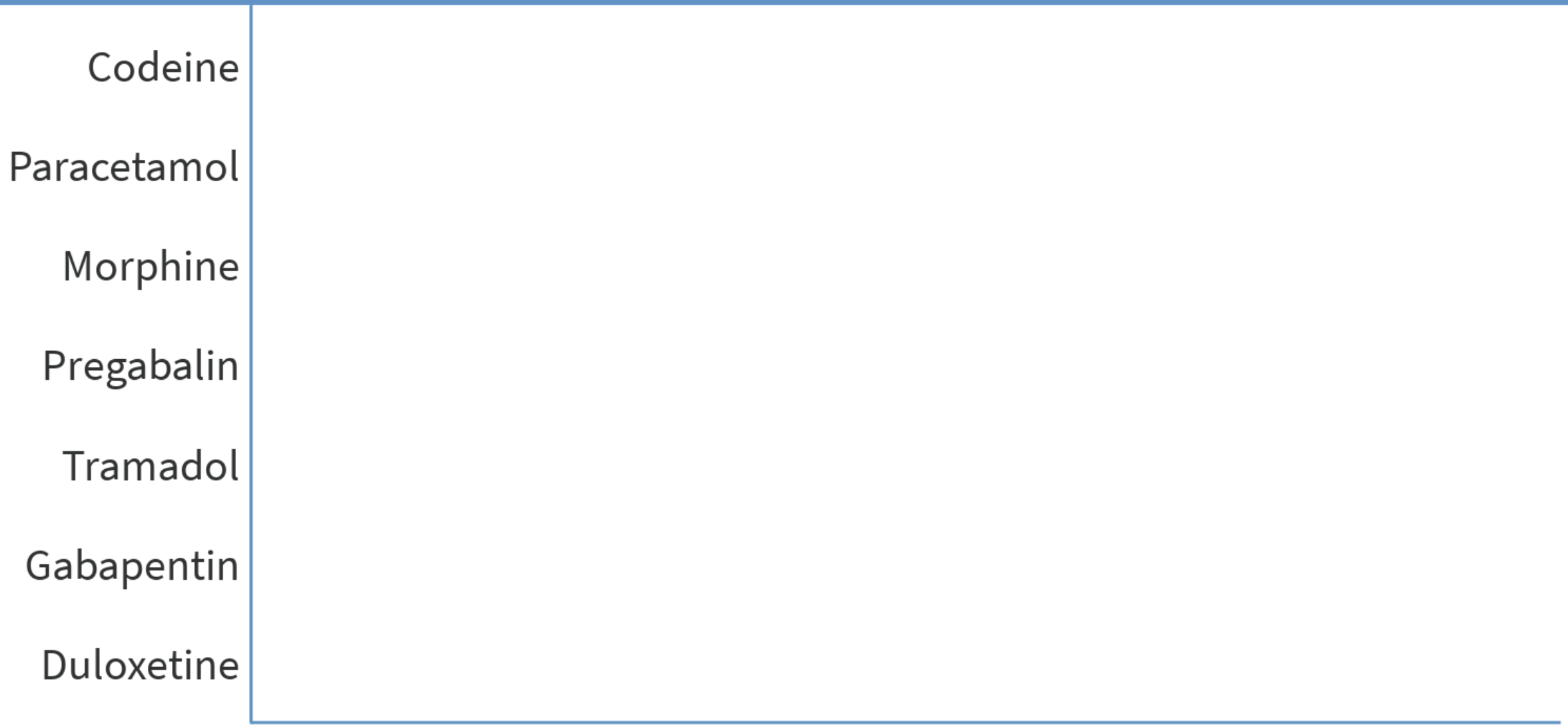
# Vitamin D

- For most other conditions – vitamin D is OTC.
- Exceptions: Deficiency or insufficiency, bariatric surgery, eating disorders on advice from specialist, on bisphosphonate 'holiday'.
- Deficiency: Prescribe the treatment phase only, maintenance is OTC.
- E.G. Deficiency: Hux D3 20,000 caps: 2 per week for 7 weeks is treatment phase (NHS), then 1000-2000iu daily is maintenance phase (OTC).
- OR 1000iu-2000iu daily for 6 months = treatment (NHS) then continue OTC.

# Opioids

- What are the concerns?
  - Dependency
  - Addiction
  - Short term side-effects
  - Long term side effects
  - USA crisis!
  - Role in chronic pain?

# Which medicine has been shown to be effective in chronic pain?



# Opioids

- Why prescribe?
  - Acute pain vs chronic pain
- How to start?
  - Small quantity! Trial of opioid first, set expectations.
- How to prescribe?
  - Monthly if a controlled drug. Stick to one opioid at a time!
  - Remember to review patient – function/pain scales?
- How to continue prescribing?
  - Continually review, ceiling dose 120mg MED, trial reductions

# Opioids – other considerations

- Sometimes doing nothing is safer!
- Livewellwithpain.co.uk for professionals and patients
- Paintoolkit.org
- Rcoa.ac.uk – opioids aware – professional resource
- Social prescribing
- Conversions – Fentanyl 25mcg/hr patch = 60-90mg MED!

# 7-Steps to Medication Review

- 1. What matters to the patient?
- 2. Identify essential drug therapy
- 3. Does the patient take unnecessary drug therapy?
- 4. Are therapeutic objectives being achieved? Adherence?
- 5. Does the patient have ADR/Side Effects or is at risk of ADRs/Side Effects? Does the patient know what to do if they're ill?
- 6. Is drug therapy cost-effective?
- 7. Is the patient willing and able to take drug therapy as intended?
- Scottish Government Polypharmacy Model of Care Group. Polypharmacy Guidance, Realistic Prescribing 3rd Edition, 2018. Scottish Government

# Case Study 1

## Polypharmacy review

- Mrs MJ 90yrs old
- New resident in care home, discharged from hospital after acute confusion
- Dementia, MI, T2D, Asthma, AF.
- Meds:
  - Aspirin 75mg
  - Pregabalin 150mg BD
  - Ranitidine 150mg BD
  - Atenolol 50mg
  - Edoxaban 60mg daily
  - Glimepiride 3mg daily
  - Metformin 500mg 1od
  - Ramipril 2.5mg twice a day
  - Donepezil 10mg
  - Solifenacin 10mg
  - Combisal 50/25 1 puff twice a day
  - Ventolin PRN
  - Buscopan 10mg TDS
  - Senna 7.5mg 4 at night

# Potential problems with Mrs MJ medications? Number 1 priority?

# Potential problems with Mrs MJ medications? Number 2 priority?

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# Some ideas

- Frailty?
- Anticholinergic Central Burden (ACB)
- Solifenacin for bladder spasm?
- HF or not?
- Interactions with donepezil
- DOAC and antiplatelet
- Hypo risk with sulfonylurea
- Risk of AKI
- Pregabalin dose/need
- DOAC dose

# Some ideas

- What does the patient think? Or carers/family?
- Essential? Edoxaban? Combisal? Atenolol?
- Unnecessary? Aspirin? Anti-diabetics? BP meds? Solifenacin?
- Therapeutic objectives being met? What are they? QOL?
- At risk of side-effects? Bleeding, hypoglycaemia, falls, many more.

# Case Study 1

## Polypharmacy review

- Mrs MJ 90yrs old
- New resident in care home, discharged from hospital after acute confusion
- Dementia, MI, T2D, Asthma, AF.
- Meds:
  - Aspirin 75mg (post MI)
  - Pregabalin 150mg BD (Lower back pain)
  - Ranitidine 150mg BD (While on aspirin)
  - Atenolol 50mg (HF)
  - Edoxaban 60mg daily (AF)
  - Glimepiride 3mg daily (T2D)
  - Metformin 500mg 1od (T2D)
  - Ramipril 2.5mg twice a day (HF)
  - Donepezil 10mg (Dementia)
  - Solifenacin 10mg (Bladder Spasm)
  - Combisal 50/25 1 puff twice a day (Asthma)
  - Ventolin PRN (Asthma)
  - Buscopan 10mg TDS (IBS)
  - Senna 7.5mg 4 at night (Constipation)

# Anticholinergic Central Burden

- Be aware of it
- Any burden can decrease cognitive activity
- Association with increased mortality
- May worsen memory and dementia
- Shown to increase risk of dementia

# Name a drug with a definite anticholinergic central burden effect

# Some ACB drugs

- Amitriptyline
- Oxybutynin
- Solifenacin
- Tolterodine
- Hyoscine
- Paroxetine
- Carbamazepine
- Quetiapine
- Chlorphenamine

# Case Study 2

## Polypharmacy review

- Mr DS, 74 yrs old
- Fibromyalgia, asthma, anxiety.
- Attends for review of medications
  - Aspirin 75mg
  - Naproxen 500mg BD
  - Zapain 30/500mg 2 PRN
  - Fencino 50mcg/hr
  - Diazepam 5mg TDS prn
  - Salbutamol 100mcg inhaler
  - Tramadol 50mg 1-2 QDS prn
  - Senna 7.5mg 2on
  - Docusate 100mg 2BD
  - Amitriptyline 50mg nocte
  - Sertraline 100mg daily
  - Pregabalin 200mg BD

# Potential problems with Mr DS medications?

# Potential problems with Mr DS medications? Number 2 priority

# Some ideas

- What does the patient think? (asthma is main concern)
- Essential? Any?
- Unnecessary? Aspirin.
- Therapeutic objectives being met? What are they?
- At risk of side-effects? GI issues, sedation, dependence, constipation, bronchospasm.
- Opioids: rationalise, currently on 3 opiates.
- High risk patient: Opioid, benzo, pregabalin and antidepressant.

# NSAIDs and new GP contract

- 'Prescribing Safety Quality Improvement' section – 37 points
- "Reduce the rate of potentially hazardous prescribing, with a focus upon the safer use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at significant risk of complications such as gastro-intestinal bleeding."
- Lots to consider!
  - Risk of GI effects
  - Risk of CVD
  - Contra-indications
  - Gastro-protection
  - NSAID vs COX-2 inhibitors

# Contra-indications to COX-2 inhibitor use?

# COX-2 inhibitor contra-indications

- Ischaemic heart disease.
- Inflammatory bowel disease (COX-2 inhibitors only).
- Peripheral arterial disease.
- Cerebrovascular disease.
- Congestive heart failure (New York Heart Association [NYHA] classification II–IV).
- **ALL NSAID CI's:** Severe heart failure, severe hepatic or renal impairment, current/previous GI bleed related to NSAIDs, aspirin allergy.
- Plenty of cautions too – HTN, diabetes, smoking……

# Risk factors for NSAID induced GI adverse events?

# Risk factors for NSAID induced GI adverse events

- Aged over 65 years or a high dose of an NSAID or a history of gastroduodenal ulcer, GI bleeding, or gastroduodenal perforation.
- Concomitant use of medications that are known to increase the likelihood of upper GI adverse events (for example, anticoagulants, corticosteroids, selective serotonin reuptake inhibitors [SSRIs]).
- A serious comorbidity, such as cardiovascular disease, hepatic or renal impairment (including dehydration), diabetes, or hypertension.
- Heavy smoking, excessive alcohol consumption.
- Previous adverse reaction to NSAIDs.
- Prolonged requirement for NSAIDs.
- High risk >2 risk factors, moderate risk = 1-2 risk factors, low risk = 0 risk factors

# So what?

- High risk = COX-2 inhibitor + PPI
- Moderate risk = COX-2 inhibitor alone OR NSAID + PPI
- Low risk = NSAID
- Drug interactions!
  - Aspirin
  - Anticoagulation
  - ACE and/or thiazides
  - SSRI/SNRI
  - Corticosteroids
  - Lithium
  - MTX and lots more……..

# Summary

- Don't prescribe any medicine without an exit plan
  - Make it clear to patient and in notes when/how a medicine should continue or when it should stop
- Never assume a patient takes their prescribed medication as 'prescribed'
  - Learn how to check 'usage' on your computer system
- Embrace your pharmacy colleagues!
- 'De-prescribing' is good, but not as good as 'not prescribing' or 'exit strategy' initiations

# Thank You

QUESTIONS?