Doncaster & Bassetlaw Teaching Hospitals
NHS Foundation Trust

PRESCRIBING MATTERS

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Keeping Prescribers up-to-date on Medicines Management Issues

Duplicate Prescribing and Supply – Reminder for Prescribers in Out Patient Clinics

A patient attended an out-patient clinic but had not brought their regular medication (delivered in a MDS, or NOMAD tray) with them.

Within the tray was a maintenance dose of dexamethasone. The patient left clinic with a new prescription for a reduced dose of dexamethasone. This was then taken in addition to the dexamethasone in the tray, effectively increasing the dose taken.

Please check if your patient has a NOMAD tray if you are prescribing medication that may already be in the tray.

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Interactions with High Risk Drugs

There have been a few incidents recently of interacting medication being prescribed with anti-rejection medication (mostly tacrolimus, ciclosporin & mycophenolate) where the clinical significance of an interaction can be extremely high.

The most common offender is clarithromycin. This can significantly increase levels of ciclosporin and tacrolimus potentially leading to nephrotoxicity.

Please be aware that the JAC electronic prescribing system does highlight this interaction but not as a "RED" warning.

Mycophenolate and co-amoxiclav is another interaction worth noting (mycophenolate levels might be reduced by up to half).

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Co-Codamol 8/500 Tablets – removal of pre-packs across the Trust

There is no evidence to show that low dose weak opioid and paracetamol preparations (e.g. Co-codamol 8/500mg, Co-dydramol) are more effective than paracetamol alone (but they still lead to opioid side effects, particular constipation). As a result, these have been removed from ward stock with immediate effect. This decision has been endorsed pain specialists across the Trust.

Where previously prescribed, please ensure that paracetamol is substituted rather than co-codamol 30/500. If a reduced codeine dose is required consider prescribing the components separately. Please direct any queries to myself rather than any other members of the pharmacy team.

Other reminders about Codeine:
Remember that 5-10% of the population are poor metabolizers of codeine and therefore the drug is likely to be ineffective, in that no metabolism will take place. In contrast, 1-2%

of the population are hyper-metabolizers and therefore likely to be particularly sensitive leading to opioid toxicity.

Codeine Use in Paediatrics:
- Codeine is not recommended for children under 12 years of age
- Codeine is not recommended for any child (up to 18 years of age) who undergo tonsillectomy or adenoidectomy (or both) for obstructive sleep apnoea
- Codeine should only be used to relieve acute moderate pain in adolescents (children aged from 12 to 18 years) only if it cannot be relieved by other painkillers - such as paracetamol or ibuprofen. Use should be limited to a maximum of 3 days
- Codeine is contraindicated in all patients of any age known to be CYP2D6 ultra-rapid metabolisers
- Codeine is contraindicated in breastfeeding mothers because it can pass to the baby through breast milk and has been associated with a fatality in the infant.
- Tramadol could be an option in adolescents
- Oral morphine sulphate 0.1 to 0.2mg/kg every 4 to 6 hour may be an alternative (although discharge supply should be limited to a maximum of 12 doses)
- Benzydamine spray (Difflam) may also be helpful in patients undergoing tonsillectomy or adenoidectomy.

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Oxycodone Prescribing/Administration

Further to yet more incidents relating to the administration of this medication, can I remind prescribers and those administering that the instant-release capsule formulation should not be used.

We recently had an incident where a patient was administered their own instant release capsules in place of their twice daily modified release tablets on numerous occasions.

If patients bring in their own instant release capsules, please arrange for these to be sent home and use oxycodone liquid for breakthrough pain while in-patient for as-required usage.

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Therapeutic Substitution

The trust operates a therapeutic substitution policy, where clinical pharmacists on wards and at the Doncaster and Bassetlaw Healthcare Services out-patients pharmacy (previously Well) can make switches to similar medications without informing prescribers.

Examples of this include:
- Prednisolone (soluble/enteric coated) to prednisolone (plain)
- Adcal D3 or Calcichew D3 forte to Calci-D tablets
- Diclofenac to ibuprofen or naproxen
- Other topical NSAIDs to ibuprofen 5%
- Other paraffin-containing emollients to zerobase
- Colecalciferol preparations from 1000unit or 20000unit to 800unit or 25000unit capsules
- Or, magnesium glycerophosphate (unlicensed) capsules to licensed Magnaspartate sachets

The rationale for these switches range from allowing the pharmacy department to buy in cost-effective alternatives (or decreasing waste by reducing the number of products available) or removing accessibility to less suitable alternatives detailed in national guidance.

For full details of this policy, see: https://tinyurl.com/y49u8fel or contact me directly via the below email address.

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BNFs & CBNFs

There are a few BNFs and CBNFs available in the Pharmacy Department. If you would like a copy of either, please contact ether Anne or Jackie on extension 644332.