Prescribing Bulletin

January 2012

To All Our Readers

Many thanks for feedback on previous bulletins. Please keep ideas rolling in for future editions.

Respiratory Prescribing Hits Local Headlines:

For this edition, we owe a huge thanks to our Respiratory Prescribing Nurse Specialist, Lynda Taylor. Lynda has been working within the Medicines Management Team this year as an 'invest to save' project and has significantly raised the profile of respiratory prescribing across NHS Borders through educational meetings directly with all practices and their respiratory prescribing decision makers, as well as at other educational sessions for GPs, pharmacists and others. Her work has been key to the guidance documents and advice which is detailed below.

Key questions for GP practices

- **What have you and your teams learnt?**
- **What prescribing changes have occurred?**
- **Could you do more?**
- **Do you need more information?**
- **When did you last check your 'top 10' drug expenditure? – it will feature at least one inhaled combination – can all the usage be justified?**

If local respiratory prescribing guidance charts had been followed for the latest 12 month period, almost £250,000 could have been saved – even taking into account the need to exclude a % of patients from any change programme.
For everyone involved in respiratory decision–making: efficient use of resources is your responsibility.

How to learn, optimise patient management and reduce costs?

Primary care respiratory prescribing accounted for £2,475,178 from November 2010 to October 2011 (latest available data) (12% of NHS Borders total Primary Care Drug Spend).

Respiratory medication and devices can be confusing to both Patients and Health Care Providers. Uncertainty around dose equivalents of inhaled corticosteroids (ICS) and/or long acting beta$_2$ agonists (LABA), not to mention the variety of inhaler devices can prove costly and may not always generate the most clinically appropriate prescription for an individual patient. Following current evidence through local prescribing guidelines is the key.

What can help?

Respiratory Prescribing Guidance charts for Asthma and COPD have been developed and approved by NHS Borders Area Drug and Therapeutics Committee (ADTC).
These support prescribers to develop individualised cost–efficient respiratory treatment plans to achieve gold standard patient care.
These charts are available on the intranet via Borders Joint Formulary or under Medical Sub-specialties–Respiratory. http://intranet/microsites/index.asp?siteid=201&uid=11.
Feedback has been very positive and **unless there are exceptional circumstances ALL prescribers should be following this guidance as follows:**

- when an inhaled medicine is initiated for the first time.
- if a change to treatment is indicated because of a change in clinical condition.
- during face to face review of stable patients when stepping down treatment.

Any new treatment or device should be commenced on a trial basis to assess response and patient acceptance.

Key Respiratory Prescribing Tips are listed as the final page of this bulletin *after the quiz which will help to test your knowledge.*
Printing the 'tips' to work alongside your laminated Respiratory Prescribing Guidance charts for Asthma and COPD is recommended to help to consolidate your knowledge.

Respiratory Interventions QUIZ

List 5 differences between Asthma and COPD.

A _____
B_____
C_____
D_____
E_____

2. What step/s on the SIGN Asthma Adult Step-wise Management Chart are Combined ICS/ LABAs recommended?

_____

3. Name the medications included in:
   A. Seretide:_____
   B. Fostair: _____
   C. Symbicort:_____

4. What type of drug is in Atimos Modulite?

_____

5. Name 3 dry powder inhaler devices on NHS Borders Asthma/COPD Respiratory Prescribing Guidance Charts:
   1. _____
   2._____
   3._____

6. Name a breath activated aerosol device

_____

7. Where can you find inhaler instructions?

8. What is the expected lung deposition of a drug given with a metered dose inhaler?

_____

9. How much did NHS Borders spend on Respiratory Prescribing in Primary Care from November 2010-October 2011.

_____

10. Number these 3 medications in order of BDP potency with the strongest dose being number 1 and the least potent being number 3:
    Seretide 125, 2p, BD
    Fostair 100/6, 2p BD
    Symbicort 200/6, 2p BD.

Respiratory Interventions Quiz ANSWERS

1. Differences between Asthma and COPD (a few)

Asthma
- Reversible
- Inflammatory
- Variable
- Non-smokers
- Any age
- Night time symptoms
- Higher DNA and non compliance

COPD
- Irreversible
- Obstructive
- Permanent/progressive
- Predominantly Smoker
- Rare under 35 years
- Rare night time symptoms
- Generally Better concordance

2. Step 3 and above

3. **Seretide**: fluticasone and salmeterol
   Fostair: beclometasone and formoterol
   Symbicort: budesonide and formoterol

4. The Long Acting Beta$_2$ Agonist; formoterol

5. **Easyhaler**
   Turbohaler
   Handihaler

6. **Easi-breathe**

7. In the box!
   NHS Borders Intranet
   On-line

8. 20%

9. £2,475,178 of which the majority was on inhalers.

10. They all fit into **the same** dose equivalent category for asthma treatment!

Key Respiratory Prescribing Tips

Glossary:
ICS: *inhaled corticosteroid(s)*
LABA: *long acting beta$_2$ agonist(s)*
SABA: *short acting beta$_2$ agonist(s)*
DPI: *dry powder inhaler(s)*

- **Brand prescribe** corticosteroid-containing inhalers –MHRA/CHM advice-*see BNF 62,p.187*

- **Reliever therapy: Do not advise** inhaling of short-acting bronchodilators prior to ICS. ***Patients and carers need educating by all health professionals that this is a waste of medication and of time as there is no evidence for any benefit.***

- **Fostair:** 1st line aerosol Combined ICS/LABA in low to moderate corticosteroid doses for Asthma
  Licensed over 18yrs.

- **Fostair and Qvar:** Have extra fine particles so are more potent that traditional beclometasone dipropionate - remember dose adjustment advice- *see BNF 62, p189*

- **Formoterol:** Recommended LABA in COPD with formulary choice as follows: 1.Formoterol Easyhaler / 2. Atimos Modulite

- **Easyhaler:** DPI choice for: salbutamol, formoterol, beclometasone, and budesonide. EMIS 'Easyhaler' listing requires careful drug and dose selection.

- **Symbicort 200/6, 1-2 puffs twice a day:** 1st line DPI in low to moderate corticosteroid doses in **Asthma.**
  Symbicort 400/12, one puff twice a day: 1st line Combined ICS in **COPD.**

- **Seretide 500 twice a day:** If the patient can use the Accuhaler effectively, Seretide 500 Accuhaler is £18.56 cheaper over 30 days than the Seretide 250 Evohaler. i.e. if 50 patients switched from Seretide 250 Evohaler to Seretide 500 Accuhaler this would save £11000/year.

- **Leukotriene receptor antagonists** are only for **Asthma** and should be discontinued if there is no clinical or symptomatic response by 8 weeks.

- **Mucolytic therapy (**formulary choice is Carbocisteine) in **COPD:** if clinical or symptomatic improvement is not achieved by 8 weeks, treatment should be stopped.

- **Oral Steroids in Adults:**

Avoid delay in rescue therapy

Asthma: Prednisolone 40mgs daily for at least 5-10 days or until recovery.
COPD: Prednisolone 30mgs daily for 7-14 days, then stop.
It may be appropriate for some patients to have a 'rescue' course of prednisolone at home, if this is agreed between the patient and the responsible health professional as part of the self-management strategy of their **Asthma** or **COPD.**
Tapering the dose of oral Prednisolone is **not** required in the majority of patients who have received less than 3 weeks of oral corticosteroid treatment and who have not recently received repeated courses (BNF 62, 2011).

- **Steroid Warning Cards:** Should be given with oral corticosteroids or **ICS**, for beclometasone equivalent doses ≥ 1000mcg/daily.

- **Haleraid Device:** Haleraid is a device to aid the administration of 120 dose and 200 dose Allen & Hanbury's aerosols. They are non-prescription items and can be obtained by the patient (or practitioner for demonstration) on request to community pharmacies at a cost of approx 80p + VAT. (not available on GP10).

- **Treatment Plans should be individual to each patient.**

- **Inhaler Choice Charts** are an evidence-based, cost efficient guide. See NHS Borders Intranet http://intranet/microsites/index.asp?siteid=201&uid=11. Whilst some other products remain in the Respiratory section of NHS Borders Joint Formulary, ***prescribers are encouraged to follow the cost-efficient guides to ensure best value for NHS money - <u>the responsibility of all.</u>***

- **Tiotropium (Spiriva) capsules:** A small number of patients feedback that they do not always feel that their tiotropium capsules deliver a dose. Boehringer Ingelheim have reminded us that the tiny amount of powder is often impossible to feel as a sensation. As long as the patient hears the capsule vibrate or rattle during use they will have received their full dose.