General Practice Updates

NHS
Stockport
Clinical Commissioning Group

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Antimicrobial Resistance

The UK Antimicrobial Resistance (AMR) strategy sets out actions to address the key challenges to AMR in order to slow and prevent the rise of antimicrobial resistant organisms.

For 2017/18 the attention remains on improving or sustaining inappropriate prescribing of all antibiotics, with a particular focus on a reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care. Stockport are currently bottom of the 12 CCGs across Greater Manchester for trimethoprim versus nitrofurantoin % prescribing rate. This means we need to be following our local and national guidance and increasing our use of nitrofurantoin where safe and appropriate to do so.

UTI in adults (no fever of flank pain)

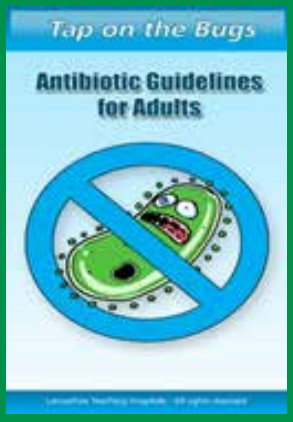
<table>
<tr>
<td rowspan="2">Treat women with severe/or ≥ 3 symptoms
Women mild/or ≤ 2 symptoms AND
• Urine NOT cloudy 97% negative predictive value, do not treat unless other risk factors for infection.
• If cloudy urine use dipstick to guide treatment. Nitrite plus blood or leucocytes has 92% positive predictive value; nitrite, leucocytes, blood all negative 76% NPV
• Consider a back-up / delayed antibiotic option
Men: Consider prostatitis and send pre-treatment MSU OR if symptoms mild/non-specific, use negative dipstick to exclude UTI.
Always safety net.
First line: nitrofurantoin if GFR over 45ml/min
GFR 30-45:only use if resistance & no alternative in treatment failure: always perform culture</td>
<td>Nitrofurantoin
trimethoprim
pivmecillinam
If organism susceptible amoxicillin</td>
<td>100mg m/r BD
200mg BD
400mg TDS
500mg -1g TDS</td>
<td>Women all ages - 3 days

Men - 7 days</td>
</tr>
<tr>
<td colspan="3">Use nitrofurantoin first line as general resistance and community multi-resistant Extended-spectrum Beta-lactamase (ESBL) E. coli are increasing. Trimethoprim (if low risk of resistance) and pivmecillinam are alternative first line agents.
Risk factors for increased resistance include: care home resident, recurrent UTI, hospitalisation >7d in the last 6 months, unresolving urinary symptoms, recent travel to a country with increased antimicrobial resistance (outside Northern Europe and Australasia) especially health related), previous known UTI resistant to trimethoprim, cephalosporins or quinolones
If increased resistance risk, send culture for susceptibility testing & give safety net advice. If GFR<45 ml/min or elderly consider pivmecillinam.
If concerned that oral treatment may not be sufficient (or first line treatment has failed), discuss with microbiology as alternative oral treatments or IV antibiotics at home may be appropriate.</td>
</tr>
<tr>
<td colspan="4">People > 65 years: do not treat asymptomatic bacteriuria; it is common but is not associated with increased morbidity.</td>
</tr>
<tr>
<td colspan="4">Catheter in situ: antibiotics will not eradicate asymptomatic bacteriuria; only treat if systemically unwell or pyelonephritis likely.
Do not use prophylactic antibiotics for catheter changes unless history of catheter-change-associated UTI or trauma.</td>
</tr>
</table>

Full guidance and microbiology contact details can be found here: Stockport antibiotic guidance (log in required).

Public Health England (PHE) have produced a patient Urinary Tract Infection (UTI) information leaflet, designed to be used during consultation with women who are experiencing non complicated UTIs. It is a useful tool for clinicians to use where the clinician feels that the patient does not require an antibiotic prescription. It includes information on illness duration, self-care advice, prevention advice and advice on when to re-consult. Use of this leaflet has been approved by PHE, RCGP, NHS Wales, Scottish UTI Network (SUTIN), RPS and BIA.

Please ask a member of the medicines optimisation team if you require paper copies of the above documents.



To get the most up to date information we recommend use of the Antibiotic Prescribing App - “Tap on the Bugs”. It is available on both Android and Apple devices via your app store.

The app is hosted by Lancashire Teaching Hospitals – both Stockport and Preston Guidelines are on there. Please make sure you use the Stockport Guidelines, both the Community and Hospital Antibiotic Guidelines are provided.

If there are any additions or modifications you would like to suggest contact sntr.pathologyenquiries@nhs.net

Clostridium difficile

There have been 56% inappropriate antibiotics prescribing reported by HPT (and long term PPI prescribing) which invariably increases the risk of C.difficile.

Action for practices:

- Do not repeat testing in people with positive C.difficile infection if the person is still symptomatic within a period of 28 days unless there is suspicion that diarrhoea is caused by a different reason. The Department of Health guidance advises that "positive results on the same individual within 28 days of the first specimen should be regarded as a single episode”.

- This implies that “separate episodes of C.difficile should be reported if positive results on the same individual were reported more than 28 days apart, irrespective of the number of specimens taken in the intervening period, or where they were taken. If a new episode is reported under the 28 day rule, this rule is reset for the new episode".

- Consider a review of the total volume of antibiotics prescribing; the use of quinolones and cephalosporins prescribing, long term PPI prescribing (especially within the at risk group of patients aged over 65) against local and national data.

Further details on antibiotics associated diarrhoea can be found here.

Type 2 diabetes management

NICE have updated their guidance on the management of type 2 diabetes to allow more flexibility around the use of the SGLT-2 inhibitors (canagliflozin, dapagliflozin, and empagliflozin).

The algorithm has been revised to allow these agents to be used as initial therapy where metformin is contra-indicated or not tolerated. Please note that metformin is still the first line treatment of choice.

A DPP 4 inhibitor, pioglitazone or a sulfonylurea are also options for initial management where metformin cannot be used.

Individual management plans, including targets agreed with the patient should guide your choice of agent at review.

To read more, click here.

Please bear in mind the safety alerts for these agents on increased risk of diabetic ketoacidosis, and lower limb amputation.

MHRA Drug Safety Alert - April 17

Valproate and developmental disorders: new alert asking for patient review and further consideration of risk minimisation measures.
The advice to prescribers are:

- Do not prescribe valproate medicines for epilepsy or bipolar disorder in women and girls unless other treatments are ineffective or not tolerated; migraine is not a licensed indication
- Ensure women and girls taking valproate medicines understand the 30–40% risk of neurodevelopmental disorders and 10% risk of birth defects and are using effective contraception
- Valproate use in women and girls of childbearing potential must be initiated and supervised by specialists in the treatment of epilepsy or bipolar disorder

Please ensure that patients who are reviewed have suitable notes made in their clinical record.

Improving adherence with amitriptyline – avoid high doses initially

Amitriptyline is first line for the treatment of neuropathic pain for patients in whom paracetamol alone is not enough to control symptoms. Used appropriately it is both effective and well tolerated,

Although the daily dose can go as high as 100mg, the recommended starting dose in chronic pain guidelines is 10mg daily and some clinicians suggest initiating at 5mg a day. Whilst starting at a higher dose might provide a faster onset of relief from symptoms it can also result in development of intolerable side effects and reluctance for the patient to continue with treatment. If needed, upwards titration of the dose should be by increments of 5-10mg at intervals of 2 weeks to achieve maximum effect. Effective use of amitriptyline can avoid escalation to other potent and potentially addictive agents.

PBMC Corner

The PBMC training sessions were held on the 16th & 25th of May 2017 and featured two new SOPs for implementation over the coming weeks.

The first SOP was to move to using Isomol emollient, presented by Mike Walker
We are looking to change those who use Doublebase gel (as well as generics and equivalent brands) to Isomol gel.

Isomol Gel

- Licensed for eczema, psoriasis and other dry skin conditions.
- Identical lipid formulation to Doublebase gel (though excipients differ slightly).
- Free from common sensitisers (irritants).
- Soap free, detergent free, fragrance free and lanolin free.
- Flex-dispenser pack to reduce waste.
- 500g Isomol = £2.92, 500g Doublebase = £5.83 – almost half the price. (Current spend on these emollients about £100K a year)

Pack size

- Optimise to 500g In all cases. Better value to NHS (500g is cheaper than giving 200g!)
- Should see reduction in ordering if larger quantity issued.
- Will encourage more frequent use.

The second SOP supports the review of prescribing inn Cow's Milk Protein Allergy (CMPA), presented by Jan Grime. Using the right type of amino acid formula is important and we currently prescribe a much lower proportion of extensively hydrolysed formula, which should be appropriate for around 90% of infants with CMPA. We use far more Amino Acid formula which only around 10% of infants should require. Full details of which to use are included in the SOP and the supporting guidance.

PBMC training will be held on:
Tuesday 18th July 10.30 - 12 Boardroom Group 1 and
Thursday 27th July 13.30 - 15.00 Boardroom Group 2
Please make sure PBMCs attend one or other of these sessions to comply with the requirements for training attendance communicated earlier this year.

Prescribing Nutritional Supplements

NHS Stockport applies strict criteria for allowing nutritional supplements on prescription to ensure patients are supported and monitored, with a stronger promotion of a food first approach where appropriate. We also aim to ensure that patients are only prescribed the best value sip feeds, for clearly defined ACBS indications.

Please review the Guidance for clinicians on Prescribing Nutritional Supplements for more detailed information regarding the ACBS conditions and other criteria to appropriately assess a patient's need for prescribed supplements. Other nutrition related resources such as patient leaflets on homemade supplements can also be found at the link above.

Approved ACBS conditions include:

- Total gastrectomy, intractable malabsorption, proven inflammatory bowel disease, short bowel syndrome & bowel fistulae
- Dysphagia related to:
  - Stroke (under the care of SALT or on dietetic advice)
  - Neurological conditions
  - Head, neck and oesophageal tumours
- Disease related malnutrition e.g. Severe COPD – FEV1 < 30%
- Renal failure on CAPD or haemodialysis

Patients with these conditions receiving supplements may continue to receive prescriptions. Choice of product should however be reviewed to ensure good value for the NHS. Support is available from your locality Medicines Optimisation team to assist with product choices. This is particularly important where food allergies are present.

Reminder: Powder supplements are first line. 1cal/ml sip feeds should not be used e.g. Ensure

Patients at high risk of malnutrition but **without** any ACBS indication or patients with an ACBS condition and a MUST score of less than 2 should be encouraged to continue to fortify their food and use homemade supplements. If a patient chooses not to fortify their diet they may choose to buy a supplement such as Complan®.

Patients living in supported care settings should NOT be prescribed supplements unless they have been reviewed by a dietician. The care setting can make/offer equivalent home-made supplements.
Guidance on fortifying food can be found in the nutrition section of the CCG website.

These recipes are also suitable for patients in their own homes who can make their own supplements or have them made for them by a carer or family member. These recipes are usually tastier that the manufactured products. Fresenius products had the best palatability in recent local taste testing.

Sunscreen

The intermittent spells of sunshine bring an increase in prescription requests for sunscreen.

A reminder of conditions eligible under the ACBS scheme:

ACBS Eligible Conditions	Examples of Ineligible Conditions

• Abnormal cutaneous photosensitivity resulting from genetic disorders, including:
  • polymorphic light eruption (PLE)
  • discoid lupus erythematosus
  • actinic prurigo
  • chronic actinic dermatitis
  • solar urticarial
  • hydroa vacciniforme
  • xeroderma pigmentosum
• Photodermatoses, including vitiligo and those resulting from radiotherapy
• Chronic or recurrent herpes simplex labialis
	• Actinic (solar) keratosis
	• Skin cancer (melanoma, basal cell carcinoma)
	• Risk of skin cancer
	• Prevention of skin-reactions in patients prescribed photosensitising drugs
	• (e.g. doxycycline, azathioprine, amiodarone)
	• Eczema
	• Psoriasis
	
	NB –high SPF sunscreen for the above conditions can be bought from pharmacies/supermarkets. Some patients may find child-friendly formulations more suitable for sensitive skin

NOTE: only the following products may be prescribed under the ACBS scheme (i.e. NHS Stockport Grey list): • LA Roche-Posay Anthelios XL SPF 50+ Cream • Sunsense Ultra (Ego) SPF 50+ • Uvistat Lipscreen SPF 50 • Uvistat Suncream SPF 30 • Uvistat Suncream SPF 50 Any other sun-protection product is blacklisted.	There may be some confusion at times regarding patients undergoing active treatment for cancer. These patients are eligible for free prescriptions (with a valid exemption certificate) but sunscreen is still **NOT** a prescribable item for these patients.

Action for practice

Patients making inappropriate requests should be advised that they need to purchase OTC and follow sun protection guidance:

- spend time in the shade between 11am and 3pm
- make sure you never burn
- cover up with suitable clothing and sunglasses
- take extra care with children
- use at least factor 30 sunscreen

BNF advice:
For optimum photoprotection, sunscreen preparations should be applied thickly and frequently (approximately 2 hourly). In photodermatoses, they should be used from spring to autumn. As maximum protection from sunlight is desirable, preparations with the highest SPF should be prescribed.