Upper GI bleeds and re-prescribing an NSAID or SSRI

A Danish observational study of 3652 patients, has found that, in the year after being discharged from hospital following a drug-related upper gastrointestinal bleed (UGIB), 25% (for NSAIDs) and 82% (for SSRIs) of people redeemed a prescription for the drug that was associated with that bleed. Proton pump inhibitors (PPIs) were generally co-prescribed, especially for NSAIDs (97%), but for those prescribed a SSRI in the 12 months following an UGIB, 25% of patients were NOT co-prescribed PPI protection.

Prescribers should follow the NHS Rotherham NSAID risk reduction strategy and consider simple analgesia or topical NSAIDs instead of oral NSAIDs in patients with GI or CV risk factors. If an oral NSAID is required, this should be at the lowest dose for the shortest period of time and PPI protection considered in line with the NHS Rotherham strategy and NICE guidelines.

Due to the risk of GI bleeds associated with SSRI, NHS Rotherham has a key prescribing indicator for the percentage of > 65 year olds taking an SSRI without a PPI. This indicator shows that in Rotherham 48.6% > 65’s year olds (range 0% - 78.6%) do not have gastro-protection with a PPI, and shows that the knowledge of GI risk with SSRIs has been slow to catch up with that of NSAIDs.


NSAID use post MI increases CVS risk.

Another Danish study followed 44,608 patients that received a prescription for an NSAID following an MI. The endpoints were all-cause death, and a composite endpoint of coronary death or non-fatal MI.

During the 5 years follow-up, 36,747 (37%) patients died and 28,693 (29%) experienced a composite endpoint of coronary death or nonfatal recurrent MI.

- Relative to non-current treatment with NSAIDS, the use of any NSAID in the years following MI was persistently associated with an increased risk of death after one year and 5 years.
- Diclofenac was associated with the highest risk and naproxen the lowest.
- NSAID use was associated with an increased risk of coronary or nonfatal MI and diclofenac was again the worst NSAID.

The authors conclude that the use of NSAIDS was associated with a persistently increased CVS risk following an MI. This absolute increase in risk is persistent for patients that continue to take NSAIDS, whereas in patients not taking NSAIDS the risk declines. The Key Prescribing indicators show that 3.2% of CHD patients are taking an NSAID (September 2012) this is down from 4.2% 12 months ago.

Discontinued = Epanutin® capsules,

Epanutin® capsules, have been discontinued and the alternative is Phenytoin Sodium Flynn Hard Capsules®, which is identical to the Epanutin brand. The manufacturer of Epanutin® has been transferred to another company the formulation remains the same but the original company has retained the brand name Epanutin® which will still apply to tablets and chewable tablets.

Action for practices. On most practice systems Phenytoin Sodium Flynn Hard Capsules is not an option to select. However there is only one phenytoin capsule preparation available in the UK. Practices are therefore advised to change all prescriptions for Epanutin® capsules to generic Phenytoin capsules.

Supply Problem with Typhoid Vaccine.

There is currently a supply problem with the Typhim Vi® vaccine. Sanofi Pasteur has provided specific information regarding the availability. For current account holders who have not placed an order, a maximum of 5 doses can be ordered, if current account holders have previously ordered, they will not be able to place another order (of a maximum of 5 doses) until December. Typherix® is out of stock until the end of 2013.

There is a live oral Typhoid Fever vaccination product called ‘Vivotif’ available from Crucell. Patients would be required to obtain this via a prescription from a pharmacist and follow the instructions on the patient information leaflet (one capsule on days 1, 3 and 5). It is licensed for children over 6 years old and should provide immunity 7-10 days after the last dose.

Shingles and Zostavax®

Recently, it has become apparent that the manufacturer of this vaccine has approached practices regarding it’s use. Currently, there is no PGD to cover this vaccine and there is no plan for a PGD to be introduced in the future (unless recommended by national guidance).

Zostavax is a vaccine indicated for the prevention of herpes zoster (shingles) in individuals 50 years of age and older. If a GP makes a judgment that vaccination against shingles would be clinically indicated and beneficial for an individual patient, then Zostavax® can be prescribed on the NHS, however, as this is not a universal programme no additional funding for delivery of the vaccine will be available. Full information regarding the recommendations for the use of this vaccine can be found at https://www.wp.dh.gov.uk/immunisation/files/2012/07/Green-Book-Chapter-34-v2_0.pdf.
MRSA and antibiotic prescribing

MRSA and appropriate antibiotic prescribing in primary care audit
NHS Rotherham continues to have low rates of cephalosporin and quinolone prescribing compared to national prescribing rates. This is encouraging because these antibiotics in particular encourage the emergence of MRSA and other resistant organisms. Despite this, MRSA bacteraemia’s still occur, which may be linked to potentially inappropriate antibiotic therapy. In April 2012 an audit of appropriate antibiotic prescribing in MRSA positive patients was carried out across all GP practices, the purpose of which was to examine the coding of patients known to be positive for, or with a history of, MRSA. Patients were flagged as either, active/current, or as past/inactive. Any antibiotic prescribing that could have been potentially inappropriate was also noted. Data was collected on MRSA patients recorded after 1/1/2008 as this was the date that practices were requested to flag MRSA positive patients.

The results showed that:

- The prescribing of inappropriate antibiotics was reduced where the MRSA status was recorded as current/active.
- That there is a need for improved education around prescribing of antibiotics in patients who were flagged as past/inactive, (i.e. have ever been, MRSA positive) and that there is room to reduce inappropriate prescribing in those patients known to be/have been MRSA carriers.

Recommended Action: Ensure all MRSA coded patients have their MRSA status recorded as an active/current medical problem in their notes. The Medicines Management Team can help support practices with this.

This audit will be repeated in April 2013 to see if there has been any improvement in the recording of MRSA in current/active problems and if this is linked to a reduction in inappropriate prescribing for MRSA positive patients.

Revised Infection Prevention and Control letter for MRSA positive patients
In view of the results from the audit above, we have worked with the Infection Prevention and Control Team and amended the letter that is sent to GPs informing them when patients are first identified as MRSA positive to remind practices of some key points which are as follows;
- MRSA is resistant to Beta-lactam Antimicrobials such as Flucloxacillin, Co-Amoxiclav, Cephalosporins and other agents such as Ciprofloxacin. Alternative agents should be used where possible or antibiotics to cover the MRSA infection must also be given at the same time.
- The correct MRSA read code must be recorded in the patient’s clinical record as an active/current problem because once a patient has been identified as MRSA positive the risk of clinical infection remains throughout their life. The correct READ codes are:
  - EMIS (LV/PCS/WEB); MRSA – A3B11
  - System One (TPP); MRSA – XE0R6
- Advice on appropriate antimicrobial prescribing is available from the hospital microbiologists; direct line: 01709 428280 or 424743 or out of hours from the on call Microbiologist via TRFT switchboard 01709 820000.

European Antibiotic Awareness Day (EAAD) 18th November 2012
This is a Europe-wide public health initiative aimed at encouraging responsible use of antibiotics. It is supported in England by the Department of Health and its advisory committee on antimicrobial resistance and health care associated infections (ARHAI). The European Centre for Disease Prevention and Control has created information and educational materials for use in hospitals and primary care settings and these have been adapted for use in England. More information and resources can be obtained from http://www.nhs.uk/nhsengland/ARC/pages/AboutARC.aspx and used in conjunction with the resources in the NHS Rotherham Management of Infection in primary Care guidelines.

Management of Infection in Primary Care guidelines review date extended
The NHS Rotherham antimicrobial protocols for the management of infection in primary care are due for review in November 2012. The national HPA antimicrobial primary care guidance is being reviewed in January 2013 and so with this in mind NHS Rotherham’s guidance has been extended until the 31st of March 2013 to ensure that any new national guidance, is incorporated into Rotherham’s guidelines

(Jason Punyer)