Prescribing Newsletter

Making the most of medicines

January 2025

NHS Frimley

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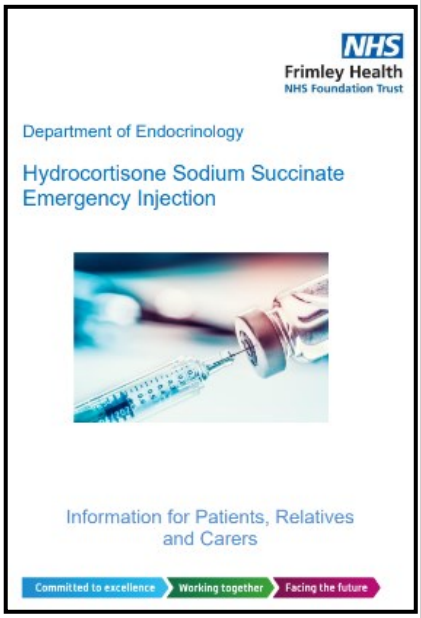
Supporting safe use of adrenal crisis emergency management kits

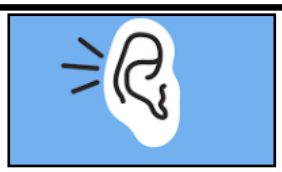
Adrenal crisis is a medical emergency, harm has occurred when patients have experienced a delay in accessing hydrocortisone rescue treatment. In line with NICE , FTHT issue patients with a rescue pack containing hydrocortisone injection to be used when they are vomiting/ or unable to take oral hydrocortisone, or otherwise at risk of adrenal crisis.



The Trust's leaflet "***Hydrocortisone sodium succinate emergency injection- information for patients, relatives and carers***" may be found in the Endocrinology folder on DXS. Occasionally kits issued by the hospital go out of date before use so patients may ask their GP to replace the contents; this may include a small number of sundry items such a needles and swabs.

More information about supporting these patients can be found on the SPS website here

Look alike sound alike (LASA) medication promazine/promethazine



Primary care colleagues are being reminded to apply caution when prescribing or dispensing two similar sounding medications. Surrey and Borders NHS Partnership Trust (SABP) has highlighted incidents where **promazine**, an anti-psychotic medication, and the similar sounding **promethazine,** an antihistamine medication, have been confused and incorrectly prescribed by local clinicians.

The two medications are known as '***look alike sound alike***" (LASA) medications. As well as having similar sounding names, similarities are compounded by other factors such as similar packaging, tablet appearance and tablet strength.

SABP is aware of cases where promazine and promethazine have been confused, either at the prescribing or dispensing stage. There is also the possibility that the two medicines may have been mistakenly referred to within electronic patient records during the documenting of encounters.

Medicines safety colleagues across Surrey Heartlands and Frimley Health and Care are reviewing cases where promazine has been prescribed to check whether the drug has been prescribed/ administered in error. Where such cases are identified, a case note review will be carried out to determine the intended medicine. Appropriate plans will be put in place to discuss identified cases with all relevant teams involved in the patient's care.

Alerts are being added to electronic prescribing and dispensing systems, for example OptimiseRX will ask prescribers selecting promazine to double check the intended medication/ indication.

For more details contact alison.marshall@sabp.nhs.uk (Medicines Safety Officer – SABP) or Melody.chapman@nhs.net (Medicines Safety Lead, Frimley Health)

Pharmacy and Medicines Optimisation Scheme (PMOS) - support with EMIS searches

Those working on this year's PMOS programme will be familiar with accessing SOPs and other supportive resources via our Teams Link. In this folder there is also a stand-alone document describing how to use, and interpret, the EMIS searches we have provided.

Please seek out this useful document to get the best out of the searches.

Please send a request to your usual MOT pharmacist if you are working on the PMOS scheme and do not have access to these folders.

BMS - joint guideline on management of unscheduled bleeding on HRT– implementation

To support healthcare professionals with the implementation of joint guideline on the management of unscheduled bleeding on HRT, the Lead Authors, together with colleagues in the NHS Faster Diagnosis Programme Team, have collated a list of the frequently asked questions, access the FAQ here.

Under-recognised risk of toxicity of propranolol in overdose

In 2022-2023 the National Poisons Information Service (NPIS) received 358 enquiries involving intentional propranolol overdose. In 12 of these cases the overdose resulted in death.

Propranolol is very toxic in overdose. Please see the GPC's Patient safety spotlight: propranolol in overdose and the report published by the Health Services Safety Investigations Body (HSIB) (here). The medicine is also cited in numerous Prevention of Future Deaths Reports. **However fatalities across the UK continue to be reported.** The HSIB report identified certain groups of patients may be at an increased risk of using propranolol for self-harm due to the underlying indication for its use eg,, co-existing migraine, depression or anxiety. The report led to warnings being added in the BNF and amendments to the NICE guidelines for headaches in relation to prescribing propranolol. Although propranolol is licensed for use in anxiety management, it is not included as a treatment option in the NICE guidance. **Propranolol would not normally be considered a first or second line treatment for the management of anxiety and its symptoms. Please note the first line treatment for anxiety is usually an SSRI.**

A recent search of prescribing in primary care in Frimley ICS shows significant numbers of patients with a diagnosis of anxiety/ phobia/ panic attacks are prescribed propranolol. We have added this search to EMIS Enterprise as below.

Name of search: **Propranolol - low dose issues in anxiety, depression & migraine**
EB: MOT -> Medicines Safety -> Newsletter ->
NEHF: Medicines Management-> 2024-25 -> Medicines Safety -> Newsletter ->
SH: MOCH Anon -> Medicines Safety -> Newsletter

Suggested actions

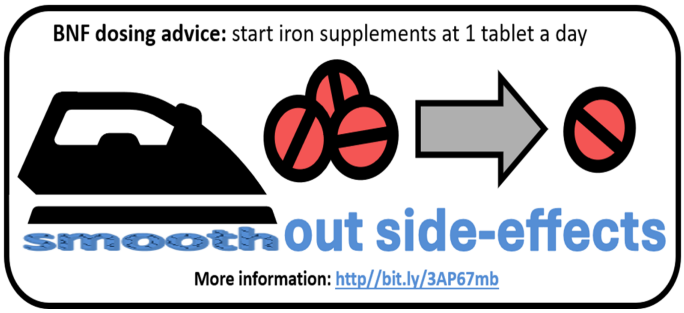
- Use a shared decision making approach to discuss the risks (including risk of overdose) versus benefits of propranolol before initiation.
- While the patient numbers per practice may be high it may be possible to internally further triage this search to patients at risk of self harm or overdose and especially target those for further review.
- Quantities prescribed at any one time should be under regular review, as should the clinical need for the medicine.
- Consideration should also be given to prescribing for occasional use, rather than a medication taken regularly.

Adapted from communication provided by SABP.

Heylo™ sensor for people with an ileostomy or colostomy

Coloplast has produced a digital leakage notification system, Heylo, for people living with stoma. The manufacturer hope that it will allow users to track potential leakages, reducing anxiety and providing reassurance and control. The appliance **does not** prevent leakage or reduce appliance/ accessory use. Patients experiencing regular or unusual appliance leakage should be advised to contact their local stoma nurse specialist for review. It maybe that due to a change in body shape, ageing, weight loss/ gain or peristomal skin problems, a change in appliance / accessory is advised.

As a new device, Frimley ICB will work with local NHS stoma nurses and assess any formulary application in the usual manner, and if approved, decide its best use in practice. Until then, **Frimley ICB does not commission use, and it remains NON FORMULARY**. We currently have a number of patients prescribed this product our spend being the 2nd highest ICB in England (despite being one of the smallest by population). **Please inform patients or stoma nurses making a prescribing request for the Heylo system that it is currently non formulary and not funded by the NHS in Frimley ICB.** Stoma nurses are asked to contact the MOT directly if they believe their patient demonstrates exceptionality.



See our resources for this campaign **here**

Frimley ICB Learning From Patient Safety Events (LFPSE) lessons and feedback

A local incident report has highlighted the need to ensure that patient medication records are accurate and up to date on EMIS.

A patient had a resurgence of menopause symptoms when she was accidentally prescribed an old, lower dose of HRT, rather than her current dose. The higher dose medication was not on her repeat list so she had been restarted from her 'past medications' and the old, lower strength, was incorrectly selected.

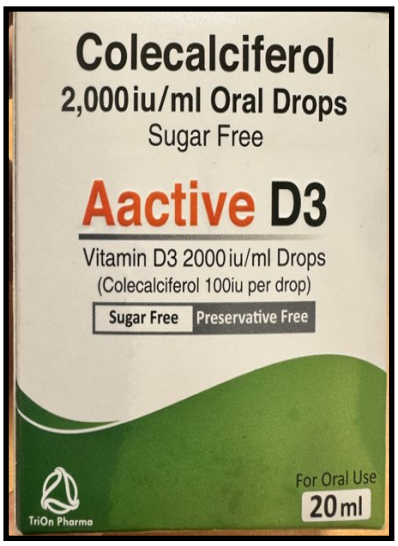
Learning points – when a medication course is ended, such as when a dose is changed, provide a reason.

*** Please continue to report events via this portal so we can share learning and feedback.***

Aactive D3 supplement recalled due to excess levels of vitamin D3 (colecalciferol)

We have been made aware of a series of children admitted to hospital in Greater Manchester with significantly raised vitamin D and calcium levels due to potential overdosing of colecalciferol. Each patient had been prescribed, or obtained, the following food supplement for which assays have now shown out of specification levels of colecalciferol. The product is a not a licensed medicine, it is a food supplement and does not fall under standard MHRA product recall processes. The products affected are;

- **Aactive D3 2,000iu/ml oral drops 20ml batch LS23317 best before November 2025**
- **Aactive D3 2,000iu/ml oral solution 50ml batch LS23318 best before November 2025**



We are not aware of any children affected in Frimley ICB; please treat this as a precautionary alert for awareness and action as appropriate.

National actions taken

- The manufacturer is aware of the issue and has quarantined the affected product.
- The MHRA and Food Standards Agency (FSA) have been notified. The FSA has issued a food recall here.

Local actions taken

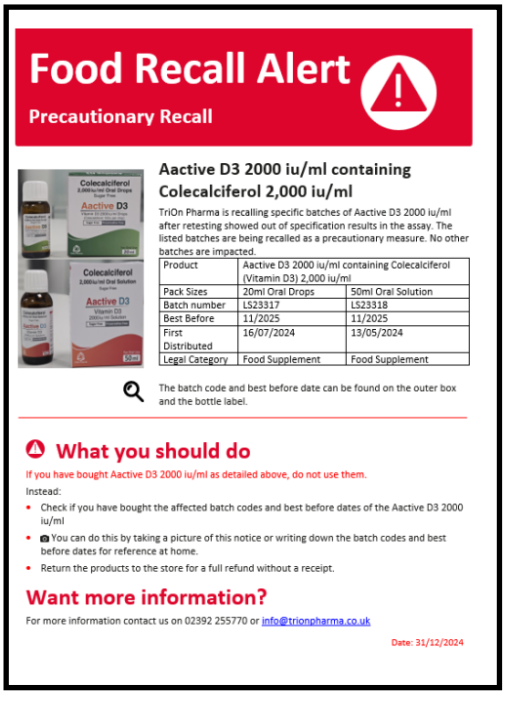
The brand, ie, Aactive D3, is prescribable via EMIS only in a different strength ie 3000units/ml. However generic prescriptions for colecalciferol 2000units/ml sugar free drops ***may*** have been fulfilled with the AActive D3 preparation. The Medicines Optimisation team have provided a search for generic colecalciferol 2000units/ml sugar free drops issued in the last 8 months. The search may be found in your EMIS Enterprise folders as below.

Name of search: **Aactive Vit D drops 2000iu/ml (as generic) recall**
EB: MOT -> Medicines Safety
NEHF: Medicines Management-> 2024-25 -> Medicines Safety
SH: MOCH Anon -> Medicines Safety

However please be aware that patients may have sourced this item OTC from pharmacies, health food shops or online. The alert from the FSA includes posters to display in GP surgeries to help raise awareness and this information has been shared with community pharmacies.

Signs and symptoms of excessive intake of Vitamin D include nausea and vomiting, weakness, lethargy, constipation and non-specific aches and pains, as well as thirst, polyuria, weight loss and cardiac dysrhythmias.

As a reminder when prescribing vitamin D local prescribers are supported by vitamin D pathways for adults and children and the Formulary lists a selection of licensed colecalciferol products. The licensed drop formulation is **colecalciferol oral drops 2,740 units/mL** (3 drops contains 200 units colecalciferol).



Food Recall Alert

Precautionary Recall

Aactive D3 2000 iu/ml containing Colecalciferol 2,000 iu/ml

TriOn Pharma is recalling specific batches of Aactive D3 2000 iu/ml after retesting showed out of specification results in the assay. The listed batches are being recalled as a precautionary measure. No other batches are impacted.

Product	Aactive D3 2000 iu/ml containing Colecalciferol (Vitamin D3) 2,000 iu/ml	
Pack Sizes	20ml Oral Drops	50ml Oral Solution
Batch number	LS23317	LS23318
Best Before	11/2025	11/2025
First Distributed	16/07/2024	13/05/2024
Legal Category	Food Supplement	Food Supplement

The batch code and best before date can be found on the outer box and the bottle label.

What you should do

If you have bought Aactive D3 2000 iu/ml as detailed above, do not use them.

Instead:

- Check if you have bought the affected batch codes and best before dates of the Aactive D3 2000 iu/ml
- You can do this by taking a picture of this notice or writing down the batch codes and best before dates for reference at home.
- Return the products to the store for a full refund without a receipt.

Want more information?

For more information contact us on 02392 255770 or info@trionpharma.co.uk

Date: 31/12/2024

Seroxat® (paroxetine hydrochloride) 10mg, 20mg and 30mg tablets discontinuation

Seroxat® 20mg tablets will be discontinued in the UK from March 2025, Seroxat® 30mg from May 2025 and Seroxat® 10mg from November 2025 for commercial reasons. Healthcare providers are advised that:

- generic versions of paroxetine hydrochloride 10mg, 20mg and 30mg tablets are available.
- in common with other SSRIs, abrupt discontinuation should be avoided as this may result in withdrawal symptoms.

Practices may identify patients on Seroxat using the EMIS Enterprise searches below:

East Berks- MOT > Mental health > Seroxat
North East Hants & Farnham- Medicines management > 2024-25 > Mental health > Seroxat
Surrey Heath- Moch Anon > Mental health > Seroxat

Novorapid FlexTouch pre-filled pens- discontinuation March 2025

No new patients are to be initiated on NovoRapid FlexTouch pens. Clinicians should pro-actively review all patients currently prescribed NovoRapid FlexTouch pens and consider switching them to another NovoRapid delivery device (FlexPen or Penfill). Decisions should take into account manual dexterity, vision, ability to use new device correctly, and whether additional support is required for administration. Clinicians could also consider switching to NHS Frimley's first line insulin aspart, Trurapi. Please see the local Formulary for details on this and to access a Patient Information Leaflet to support this change.
If the above options are not suitable seek advice from the specialist diabetes team.

Freestyle Libre 2 sensor replacement

The manufacturers will be phasing out **Libre 2** sensors at the end of August 2025. They will be replaced with **Libre 2 Plus** sensors, these will work with the current Libre 2 reader and LibreLink app. For more information see FreeStyle Libre 2 Sensor Discontinuation.
Patients prescribed FreeStyle Libre 2 sensors may start to be changed to FreeStyle Libre 2 Plus sensors from now.

Suggested Accurx message:

Change of prescription: The 'FreeStyle Libre 2 Plus sensor' is now available. You will be automatically moved over to the NEW FreeStyle Libre 2 Plus sensor at the next renewal. Please visit the manufacturer's website for further product info: https://www.freestyle.abbott/uk-en/products/freestyle-libre-2-plus-sensor.html

Practices may identify patients using the EMIS Enterprise searches below:

Name of search: **Freestyle Libre 2 sensor change to Freestyle Libre 2 Plus sensor**
EB: MOT -> Diabetes -> Freestyle Libre ->
NEHF: Medicines Management-> 2024-25 -> Projects -> Diabetes -> Freestyle Libre
SH: MOCH Anon -> Diabetes -> Freestyle Libre **->**

Emergency supplies of fidaxomicin used for treatment of *Clostridioides difficile* infection

There have been some cases where patients have not been able to fill a prescription for fidaxomicin at community pharmacies on/ near weekends due to the delivery schedules of wholesalers.

South Central Antimicrobial Network (SCAN) have been in discussions with the manufacturers of fidaxomicin who have advised that an emergency ordering service is available via Alliance. Community pharmacists may access this free service on 0330 100 0449.

Community Pharmacy Original Pack Dispensing (OPD)

Original Pack Dispensing (OPD) allows a community pharmacy the discretion to dispense plus/minus 10% of the prescribed quantity, if that could result in the medicine being supplied in the manufacturer's original pack. It has been introduced for electronic NHS prescriptions ONLY and (subject to system functionality) applies from 1 January 2025. There is no requirement for the pharmacy to inform the prescriber, however good communication between the pharmacist and the GP is encouraged.

We do not expect this to significantly impact general practice however, we want to highlight examples where patients will continue to receive the exact prescribed quantity of medication. For instance, antibiotics, where it is clinically important for patients to complete the full course or for certain pain relief medication where there is a risk of dependence or addiction. Please note that some medicines are out of scope of the Original Pack Dispensing regulations– for example controlled drugs (schedules 1-4), Special Containers, and unlicensed specials.

Please find further information in the Briefing 024/24: Original Pack Dispensing FAQs - Community Pharmacy England.

NHS Frimley Medicines Optimisation team may be contacted on frimleyicb.prescribing@nhs.net

National Medicines Advice Service

Healthcare professionals in primary care across England may contact this service on 0300 770 8564 or asksps.nhs@sps.direct