NHS
Hampshire and Isle of Wight

Prescribing and Medicines Optimisation Guidance

Issue: 87 **Date:** 1st September 2023

Safety guidance

1. Emollients and risk of severe and fatal burns- Local fatality

Emollients can transfer from the skin onto clothing, bedding, dressings, and other fabric. In the presence of a naked flame, fabric with emollient dried on is easily ignited. Although emollients are not flammable in themselves or when on the skin, when dried on to fabric they act as an accelerant, increasing the speed of ignition and intensity of the fire. This accelerant effect significantly reduces the time available to act to put out a clothing or bedding fire before serious and fatal burns are sustained. All emollients (lotions, creams, ointments, gels, sprays, soap substitutes) carry this risk. This includes all paraffin-base products regardless of percentage paraffin content, and paraffin-free products. No emollient can be considered 'safer' than another with regard to this risk.

Sadly, there has been a recent death in our ICB area, where a person accidentally set himself on fire whilst lighting a cigarette. Emollient cream had been applied that morning, causing his clothes to become impregnated. He caught alight and died as a result of his injuries.

Despite the multiple warnings from the MHRA and local Fire and Rescue teams, this fatality illustrates the ongoing need for education and awareness of this serious risk, especially to those who apply emollients regularly and smoke. There are many national resources available to help endorse the key messages:

- **MHRA Guidance :Safe use of emollient skin creams to treat dry skin conditions** LINK
  - Including patient information leaflet LINK and
  - YouTube video LINK
- **Hampshire and Isle of Wight Fire and Rescue webpage** LINK

Further support will be available through Medicines Optimisation teams to help identify (via clinical system searches) patients at greatest risk for targeted safety messages.

2. Depo-Provera injection – Learning from local incidents LINK

The ICB supports practices by analysing themes from significant events reported. On some occasions, themes or single events are identified that require prompt sharing to all primary care practices to enable learning. The July edition of Primary Care Shared Connections highlights a case where Depo-Provera injection (medroxyprogesterone 150mg/ml) was transferred to a patient's "repeat" medication list which enabled the patient to self-administer for two years, without education and health checks. Patient therefore was not receiving regular monitoring for BP, weight, and irregular bleeding as per FSRH guidelines. See link above.

3. **MHRA reinforces anaphylaxis emergency guidance as hospital admissions rise** LINK

MHRA has reinforced its safety guidance to highlight importance of knowing how to use an adrenaline auto-injector & what to do after, following new figures showing 25,721 admissions to English hospitals for allergies/anaphylaxis in 2022-23, over double the admissions in 2002-3.

4. **MHRA Fluoroquinolone antibiotics: reminder of the risk of disabling and potentially long-lasting or irreversible side effects** LINK

Healthcare professionals prescribing fluoroquinolone antibiotics (ciprofloxacin, delafloxacin, levofloxacin, moxifloxacin, ofloxacin) are reminded to be alert to the risk of disabling and potentially long-lasting or irreversible side effects. Do not prescribe fluoroquinolones for non-severe or self-limiting infections, or for mild to moderate infections (such as in acute exacerbation of chronic bronchitis and chronic obstructive pulmonary disease) unless other antibiotics that are commonly recommended for these infections are considered inappropriate. Fluoroquinolone treatment should be discontinued at the first signs of a serious adverse reaction, including tendon pain or inflammation.

5. **MHRA: Methotrexate: advise patients to take precautions in the sun to avoid photosensitivity reactions** LINK

Photosensitivity reactions are known side effects of methotrexate treatment and can be severe. Patients should be advised to take precautions to protect their skin in the sun.

6. **MHRA: Valproate: re-analysis of study on risks in children of men taking valproate** LINK

MHRA provide an update on a retrospective observational study on the risk to children born to men who took valproate in the 3 months before conception and on the need for the re-analysis of the data from this study before conclusions can be drawn. No action is needed from patients. It is vitally important that patients do not stop taking valproate unless they are advised by their specialist to do so. For female patients, healthcare professionals should continue to follow the existing strict precautions related to preventing the use of valproate in pregnancy (Valproate Pregnancy Prevention Programme).

Local guidance

7. **New clozapine resources added to HIOW ICB website** LINK

Clozapine is a high-risk, atypical antipsychotic medication that has been the subject of two MHRA safety alerts highlighting its potentially fatal side effects and toxicity in recent years (2017 and 2020).Nationally, there remains a general lack of awareness of the potential adverse drug events linked with clozapine, including clozapine-induced gastrointestinal hypomotility (CIGH). CIGH may present as abdominal pain, bloating or constipation and has a fast onset, which has resulted in fatalities.

Fact sheets for clinicians and non-clinicians (e.g., front line receptionists, pharmacy staff) have been written to highlight these key safety points via the link above.

Clozapine is a “red” (hospital/ specialist only) drug on local formularies. It is important that when prescribed by specialists it is correctly documented on GP clinical systems as a “Hospital Only” medication. Guidance on how to record hospital-only medicines on GP clinical systems is available here LINK

National guidance

8. NHSE: Liothyronine – advice for prescribers LINK

This guidance outlines where and when it may be appropriate to prescribe liothyronine in the NHS. Treatment should only be initiated by an NHS consultant endocrinologist and patients already receiving it should be reviewed by a consultant if that has not already taken place. Local restrictions are detailed in the HIOW Formulary : LINK

NICE guidelines

9. Ectopic pregnancy and miscarriage: diagnosis and initial management – updated guidance (NG126) LINK

Following a review of the evidence this guidance has several new and updated recommendations on the medical management of missed miscarriage. 200mg oral mifepristone, followed at 48 hours, by 800 micrograms vaginal, oral or sublingual misoprostol is now recommended.

10. CKS: Parenteral anticoagulants- Treatment of DVT LINK **and PE** LINK **updated**

Clinical Knowledge Summaries (CKS) for DVT and PE have recently been updated to indicate the dose of enoxaparin required in patients with additional risk factors, such as obesity or cancer (where 100 IU/kg (1mg/kg) twice daily is required), in line with the manufacturer's summary of product characteristics. The Ardens template is in the process of being updated to reflect this. In the meantime, practitioners should be aware of the enoxaparin doses required to avoid undertreating higher risk patients.

11. Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (NG158) – updated guidance LINK

Recommendations on use of Wells score & D-dimer in diagnosis of pulmonary embolism & deep vein thrombosis have been updated following a review of the evidence for people with COVID-19. Recommendation on use of the pulmonary embolism rule-out criteria has also been clarified.

Other

12. Reminder- DHSC: Medicine Supply Notification: Tresiba (insulin degludec) FlexTouch 100units/ml solution for injection 3ml pre-filled pens. LINK

- Tresiba® FlexTouch® (Insulin degludec) 100units/ml pens will be out of stock from August 2023 until January 2024.
- Tresiba Penfill® (Insulin degludec) 100units/ml solution for injection 3ml cartridges remain available and can support increased demand.
- Tresiba Penfill® cartridges can be used with the NovoPen 6® and NovoPen Echo Plus® devices.
- Ensure that patients have access to a suitable device and that the patient is thoroughly counselled on how to use this device. Information for patients on how to use NovoPen 6® is available here: LINK

Local community diabetes teams have seen a high rise in calls over this issue and advise prescribers to follow the above DHSC national advice.

13. Wessex AHSN: Wessex Polypharmacy community of practice meeting LINK
3rd October 12.00-1.30pm

Are you a GP, pharmacist, geriatrician, nurse or allied health professional with an interest in tackling polypharmacy? Join our Wessex Polypharmacy Community of Practice to share learning, ideas, resources and evidence base around tackling polypharmacy and improving medication reviews. Together our network aims to improve medication safety in Hampshire, Isle of Wight and Dorset. Register via: https://wessexpolypharmacycopoct23.eventbrite.co.uk/

14. DHSC: SSP issued for Jext® 300micrograms/0.3ml (1 in 1000) solution for injection auto-injector pen LINK

A Serious Shortage Protocol (SSP) has been issued to enable pharmacists to supply an Epipen (300 microgram strength) instead of a Jext (300 microgram strength) to help mitigate the effects of an ongoing supply disruption of the Jext (300microgram) form of adrenaline auto-injector.

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Local medicines optimisation teams can be contacted via their generic team mailbox: See LINK

Previous bulletins can be found hosted on the ICS website here: link