Health and Social Care Board

Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

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Dose reduction required when switching opioid analgesics

A GP has reported a possible adverse event that occurred when a patient taking an oral opioid was switched to an alternative opioid. The patient experienced symptoms of opioid toxicity. The dose conversion had been calculated as per local guidelines but it is thought that the side effects following the switch may have been due to incomplete cross tolerance between the opioids.

Incomplete cross-tolerance is where there is tolerance to a currently administered opioid that does not extend completely to other opioids. If the patient's medication is switched it may mean that a lower dose of the new opioid is required.

When moving to a new opioid it is recommended that a 25-50% dose reduction is applied to allow for incomplete cross tolerance.

The new regimen should then be re-titrated according to patient response. The patient should be monitored closely, especially at higher doses.

Advice to prescribers:

HSCB and Trust staff are currently developing guidance for practitioners in this area.
You are asked to be vigilant for the potential for incomplete cross tolerance and reduce patients' doses accordingly if switching opioids.

The NHS Scotland 'Managed Clinical Pain Network' website provides a useful calculator to assist with this adjustment:

http://www.jet5.com/pain/disclaimer.php

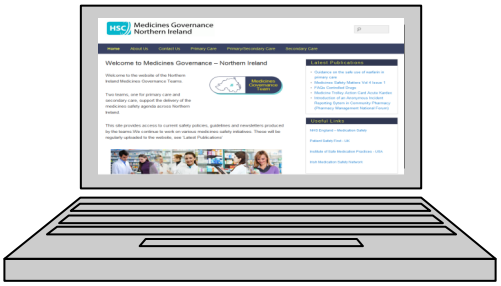
Click on the 'clinicians' area and then 'dose converter'.

New Medicines Governance website

A new HSC website has been introduced in Northern Ireland to provide access to the medicines governance resources used in both primary and secondary care.

Features of the new website:

- Open access to all internet users
- Available in mobile and desktop formats



What's on the Website?

Lithium	Newsletters
Warfarin	Contact details
Insulin	Correspondence
Methotrexate	Safety Alerts
Audits	Controlled drugs
Reporting AIs	

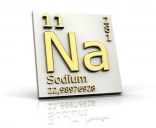
Please add to the 'favourites' list on your PC or mobile device

www.medicinesgovernance.hscni.net

Medicines combination causes low sodium

A 65 year old male who had been taking venlafaxine m/r 75mg for several years was prescribed DesmoMelt® (desmopressin) for symptoms of nocturia.
A few months later he became lethargic and unresponsive and was admitted to hospital. Whilst in hospital he had generalised tonic clonic seizures and was diagnosed with hyponatraemia.

Both venlafaxine and desmopressin can cause hyponatraemia.



Box 1 Medicines that can reduce serum sodium

Common:	Less common:
Vasopressin Desmopressin Diuretics SSRIs Antipsychotics NSAIDs Carbamazepine	Sulfonylureas Proton pump inhibitors Dopamine agonists Opioids Theophylline ACE inhibitors Angiotensin-II receptor antagonists Amiodarone Tricyclic antidepressants

What are the risk factors and causes of hyponatraemia?

The most significant risk factor is increasing age but the cause is often multifactorial.

Common causes include:
- Medicines (See Box 1)
- Syndrome of inappropriate antidiuretic hormone secretion (SIADH)
- Heart failure.

What are the symptoms?

- Early symptoms are anorexia, nausea, lethargy and apathy
- Late symptoms include disorientation, agitation, seizures and coma.

Learning for prescribers and pharmacists:

- Take care when prescribing drugs which can cause hyponatraemia, especially when one or more of these medicines are co-prescribed. Consider the need for additional monitoring.
- Don't ignore any hyponatraemia warning messages on prescribing or dispensing clinical systems.

Directions for using metronidazole gel

A pharmacist received a prescription for metronidazole gel 0.75% 40g with dose instructions to be used 'as directed'. The pharmacist was preparing to dispense a treatment for rosacea. However, when the pharmacist spoke to the patient it was apparent that they were expecting a treatment for vaginitis. The prescriber had not selected the correct metronidazole product and the prescribed dose instructions did not reflect its intended use.

Metronidazole 0.75% (40g size)	
Product	**Indications**
Metrosa® Acea® Rozex®	Rosacea
Metrogel®	Rosacea/fungating tumours
Zidoval®	Vaginitis

Learning from the near miss:
- A number of metronidazole gel products have the same generic description e.g. strength and size (see table)
- Prescribers should ensure that the intended product and dose instructions are clear on the prescription e.g. for vaginal use state 'insert 5g applicatorful at night for 5 days'.

Parenteral iron - warnings for use apply to I.M. and I.V. injection

In line with recent MHRA advice, GPs have been reviewing patients who are receiving parenteral iron. It has come to light that there are a number of patients in primary care receiving **intramuscular** injections that have not been included in these reviews.

Please note that the MHRA advice applies to **all routes** of administration for parenteral iron:

- Intravenous infusion
- Intravenous injection
- Intramuscular injection (CosmoFer® only - avoid this route if possible due to pain, ulceration etc.)

For further information see:
http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON300398

The updated warnings for parenteral iron include:

- IV iron products should only be administered by staff trained to evaluate and manage anaphylactic or anaphylactoid reactions and have **resuscitation facilities immediately available**
- Patients should be closely monitored for signs of hypersensitivity during and for at least 30 minutes after **every** administration of an IV iron product.

Advice to reduce the risk of overdose with insulin degludec

Tresiba® (insulin degludec) was launched in the U.K. in March 2013 and is available in two strengths, 100 units/ml and 200 units/ml.

It is the first insulin to have a strength greater than 100 units/ml.

Between March and November 2013, there were 240 prescriptions for the higher strength 200 units /ml prefilled pen dispensed in Northern Ireland . (Tresiba® is not included in the N.I. Medicines Formulary[1] and the Scottish Medicines Consortium do not recommend its use in NHS Scotland[2]).

Information to give to patients:

- There are two different strengths of insulin degludec
- The pen device will calculate the dose of insulin that they need irrespective of strength. Check the dose-counter window of the pen device which displays the dose in units, and make sure this matches the dose they wish to administer.
- Never count audible clicks to determine the dose to be administered
- Only use Tresiba® as instructed as using it any other way may result in a dangerous overdose
- Always check the manufacturer's packaging and dispensing label before every injection to ensure they have the correct insulin.

Advice for healthcare professionals:

- Ensure that patients have been trained in the use of Tresiba® and have been provided with the necessary information e.g. insulin passport.
- Always check the patient held insulin passport before prescribing, dispensing or administering insulin.

Prescribing:

- Ensure that the strength is included on the prescription
- Do not convert (i.e. recalculate) doses when transferring patients from one strength of insulin degludec to another - the pen device shows the number of units of insulin to be injected irrespective of strength

Dispensing:

- Ensure that the correct strength of insulin degludec is dispensed; if in doubt, contact the prescriber
- Ask patients to visually identify the strength of insulin degludec dispensed, and ensure patients are able to read the dose counter of the pen device.

Administration:

- Patients and healthcare staff must **never** use a syringe to withdraw insulin from a prefilled pen or from a cartridge.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON266132

[1] http://niformulary.hscni.net
[2] http://www.scottishmedicines.org.uk

Vaccination in pregnancy mix up

A pregnant lady was recently given the wrong vaccine to protect her unborn baby against pertussis. Her doctor administered Pediacel® instead of Repevax® which was the correct vaccine to be administered during pregnancy.[1]

Vaccine	Protects against:	Administer to:
Repevax®	Diptheria, tetanus, pertussis,polio	Children at 3 years and 4 months old Pregnant women from week 28[1]
Pediacel®	Diptheria, tetanus, pertussis,polio & haemophilis influenza type b	Children at 2, 3 and 4 months old

Advice for healthcare staff:

- Be aware of differences between Repevax® and Pediacel®.
- Store vaccines with similar packaging or names separately in the fridge
- Check the relevant Patient Group Direction as this will provide an extra check that the correct vaccine has been selected
- Ensure all prescribers are made aware of relevant communications to the practice e.g. details of enhanced services.

Important differences between other commonly used vaccines are highlighted in the PHA Immunisations poster outlining the childhood immunisation schedule.
The poster should be displayed prominently in treatment rooms and in dispensaries as this will help to reduce the risk of the wrong product being selected.

Copies can be downloaded from:
http://www.publichealth.hscni.net/publications/immunisation-poster-professionals-july-2013

[1]Boostrix IPV® will be replacing Repevax® for administration during pregnancy to protect against pertussis in new-borns, later in the year. Practices will be advised in due course.

Delivery of prescriptions to GP practices

The Board has been made aware of a number of incidents where prescription forms ordered and dispatched by the supplier were not received by the practice. When investigated it was discovered that delivery of the prescription forms had been attempted at a time when the practice was closed e.g. lunchtime, and the courier delivered the forms to an alternative address for onward delivery at a later date.

In these circumstances, the courier should have retained the forms and delivered them directly to the practice at a later date.

Advice for GP Practices:
If prescription forms are not delivered as expected, please contact the supplier - De La Rue Smurfit (Tel: 028 9262 2999).

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Medicines Safety Matters on the web: www.medicinesgovernance.hscni.net

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