Kingston GP Chambers

05/02/2022

Dear EA /MI and KEC teams,

Controlled Drug Re-audit

In October we carried out an audit of controlled Drug prescribing and sent the updated prescribing information and guidance. We have now completed a re-audit of prescribing following the update

Introduction

Chambers services provide short term care for patients and it is important that we prescribe according to guidelines and best practice. This is particularly relevant when initiating medications which may, in some way, compel their own GP to continue them.

Gabapentin and pregabalin are increasingly being prescribed to manage various pain presentations. However, the evidence for use outside of the neuropathic pain presentation is very limited.

NICE recommends the use of gabapentinoids only in the treatment of neuropathic pain (except trigeminal neuralgia). In 2020 and 2021 NICE made the following recommendations on use of gabapentinoids in other types of pain:

- Do not initiate gabapentinoids to manage chronic primary pain
- Do not offer gabapentinoids for managing sciatica and low back pain

Results

April to September 2021

54 prescriptions for oramorph/ Oxycodone/Tramadol/ gabapentin/pregabalin

Opioid prescribing almost universally appropriate and according to guidelines

9 patients had gabapentinoids initiated not according to current guidance.

- *6 acute sciatica*
- *2 back pain*
- *1 neck pain*

2 patients had gabapentin initiated according to NICE but could/ should this have been left to own GP?

- *Neuralgia*
- *Post herpetic neuralgia*

Re-audit October to December 2021

23 prescriptions for *oramorph/ Oxycodone/Tramadol/ gabapentin/pregabalin*

Opioid prescribing largely all justifiable although one patient prescribed tramadol for shoulder pain occurring only after running which may not have been best use of opioids

***4 patients** had gabapentinoids initiated not according to guidance*

Reasons:

1. *Sciatica (x 2) – alternative suggested in guidance*
2. *Pins and needles in hands and feet – longstanding - amityptilline or referred to own GP*
3. *Facial pain post Stevens Johnson syndrome – difficult case and gabapentin justifiable – could also have used amitriptyline or duloxetine as per NICE for neuropathic pain*

Discussion

This shows similar results to initial audit and this probably demonstrates how limited the options are when escalating through the pain ladder and when dealing with sciatica etc. In fact the NICE guidance for management of sciatica tells us what not to prescribe but doesn't give any good options to prescribe highlighting that non- pharmacological management is best - **'given the lack of clinical benefit for any of the pharmacological treatments of sciatica included in this review, the committee made no recommendations to offer a specific pharmacological treatment'.**

This leaves us in a tricky situation as long waiting times for imaging/ physical and psychological therapies all impact on the way we prescribe. There is, however, an increasing awareness that opioids for chronic pain and gabapentinoids for all except neuropathic pain are not useful and risk dependency.

When prescribing drugs likely to cause dependence of misuse the BNF advises that the prescriber has three main responsibilities

- **To avoid creating dependence by introducing drugs to patients without significant reason**
- To see that the patient does not gradually increase the dose of a drug, given for good medical reasons, to the point where dependence becomes more likely
- To avoid being used as an unwitting source of supply for addicts and being vigilant to methods for obtaining medications

I would suggest that before initiating these medications, where not supported by guidance, a clear discussion takes place and is documented to explain there are limited options, prescribing is not according to guidance and is off license and that if there is no noticeable benefit it is stopped.

I would also question whether Chambers type clinics are the correct place to be having this discussion and initiating this treatment, which may pressure their own regular GP to continue a medication that they wouldn't have initiated although I do understand the pressing need to treat a patient in pain.

MHRA Updates

No benefit of inhaled budenoside in covid

The PRINCIPLE trial of using 800mcg budesonide in higher risk patients with covid infection, has been reported and there is NO evidence of benefit. SO don't stop anyone's normal inhalers, but the previous recommendation to start budesonide for covid infection in higher risk patients has now been withdrawn.

Haloperidol in delirium warnings

Haloperidol warnings when used for delerium. Although NICE recommends the use at the lowest possible dose for the shortest length of time for delirium, when other non pharmacological methods have failed, they want to remind us of the risks. So they recommend a baseline ECG and correction of any electrolyte disturbance, checking for any QT prolongation, awareness of any other drugs which prolong QT and the risk of ventricular arrhythmias. Further ECG at clinician's discretion. Monitor for tardive dyskinesia, dystonias, parkinsonism features, particularly hypersalivation, dysphagia which may be a marker of swallowing issues and risk of aspiration.
In practice this could be challenging, for instance getting an ECG in the community.

https://www.gov.uk/drug-safety-update/haloperidol-haldol-reminder-of-risks-when-used-in-elderly-patients-for-the-acute-treatment-of-delirium

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Richard Hughes