NHS
West Hampshire
Clinical Commissioning Group

Medicines Optimisation news headlines

FEBRUARY 2014

1. The Newer Oral Anticoagulants (NOACs) – Update

Prescribers will be aware that we currently have three NOACs available – apixaban, dabigatran and rivaroxaban. All three have a licence for the prevention of stroke in AF and all have been evaluated by NICE and are recommended as options for the prevention of stroke and systemic embolism within their licensed indications. NICE didn't identify any sub-groups of patients in which the NOACs would be more cost effective and hasn't directly compared the three agents.

Within West Hampshire there has been a steady increase in the use of NOACs and there were over 700 items written in December 2013. The DPC has developed a decision aid which is intended to help prescribers, alongside the patient, decide which the most appropriate oral anticoagulant is. The aid can be found on our website at:
http://www.westhampshireccg.nhs.uk/documents/doc_view/385-anticoagulantdecisionaidapprovedmay2013

A number of GPs seem to be under the impression that the initiation of NOACs is restricted to specialists – this is not the case and GPs are able to initiate in the same way as they would with warfarin.

GPs will be aware of the poor evidence for the use of aspirin in preventing stroke in patients with AF. NOACs or warfarin are significantly more effective than aspirin whilst the risk of bleeding is similar. Reviewing patients with AF who are currently receiving aspirin or no treatment is one of the medicines management team's current interventions (and will be a priority for next year) and the detail aid is available at:
http://www.westhampshireccg.nhs.uk/documents/doc_view/356-13-aspirin-in-af-detail-aidapproved

For patients who have previously declined warfarin and are currently on no treatment or aspirin a NOAC might be a suitable alternative. Patients who are well controlled on warfarin should not be changed.

In conclusion the use of NOACs is increasing and NICE recommends them as an option in patients with AF. There are obvious groups of patients who might benefit, including patients whose INR control is poorly controlled on warfarin, patients who have previously declined warfarin, and patients where INR testing is problematic (for example housebound patients who require a community nurse visit). We would be grateful for your thoughts and feedback.

One disadvantage of the NOACs is that they are not as familiar to patients and others (including healthcare professionals) as warfarin (for example a recent first aid course highlighted the need to ask patients who were bleeding about warfarin but not the NOACs). The manufacturers of the NOACs have developed patient support materials and prescribers and pharmacists are asked to ensure that patients are aware that they are taking an anticoagulant and to alert other healthcare professionals.

2. Strontium – Update

The European Medicines Agency has concluded its review on strontium and has further restricted the use of strontium. Their guidance to healthcare professionals is as follows:

Healthcare professionals in the EU Member States will receive a letter informing them of the updated recommendations on the use of Protelos/Osseor. The letter will advise them of the following:

Protelos/Osseor should only be used to treat severe osteoporosis in postmenopausal women and men at high risk of fracture, for whom treatment with other medicinal products approved for the treatment of osteoporosis is not possible due to, for example, contraindications or intolerance;

Protelos/Osseor must not be used in patients with established, current or past history of ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease, or those with uncontrolled hypertension;

Doctors should continue to base their decision to prescribe Protelos/Osseor on an assessment of the individual patient's risks. The patient's risk of developing cardiovascular disease should be evaluated before starting treatment and on a regular basis thereafter, generally every 6 to 12 months;

A reminder that the local osteoporosis guidelines recommend that oral bisphosphonates, strontium ranelate and raloxifene are recommended for up to five years of treatment:
http://www.westhampshireccg.nhs.uk/documents/doc_view/390-osteoguidelines18thjune2013

Neil Hardy
Head of Medicines Management
neil.hardy2@nhs.net
023 8062 7864

Dr Greg Warner
Clinical Director - Medicines Management
greg.warner@nhs.net