NHS
West Hampshire
Clinical Commissioning Group

# Medicines Optimisation news headlines

## July 2016

This month's newsletter has a safety theme, focusing on drugs that have been associated with serious toxicity.

**Co-proxamol –The facts**

Safety concerns:

- Dextropropoxyphene can have serious effects on the electrical activity of the heart even at normal therapeutic doses.
- The lethal dose of co-proxamol is relatively low and can be potentiated by alcohol and other CNS depressants.
- Death from co-proxamol overdose can occur rapidly, even before hospital treatment can be received.
- The risk of dying after co-proxamol overdose is 2.3 times that for tricyclic antidepressants and 28.1 times that for paracetamol.
- Risk of addiction, abuse and overdose can extend to others in the household.

No patient group has been identified in which the risk: benefit ratio of using co-proxamol is positive.

There is no robust clinical evidence that co-proxamol is more effective than full strength paracetamol in either acute or chronic use.

Co-proxamol is an unlicensed medicine so all prescribing responsibility rests solely with the prescriber.

West Hampshire CCG does not support prescribing of co-proxamol.

It is now 11 years since the marketing authorisation was withdrawn and there are still 100 prescriptions for co-proxamol written each month within west Hampshire.

Members of the Medicines Management Team will be visiting all practices to identify patients currently receiving co-proxamol. An Intervention Brief will be available to assist with decisions around alternative treatment.

**MHRA Drug Safety Update**

1. There have been some reports of calciphylaxis in patients taking warfarin, some unexpectedly when renal function was within normal limits. If calciphylaxis is diagnosed, appropriate treatment should be started and consideration should be given to stopping treatment with warfarin.

2. There is a suspected drug interaction between citalopram and cocaine that could lead to subarachnoid haemorrhage. Prescribers should consider enquiring about illicit drug use when initiating citalopram.
3. Occurrence of pulmonary hypertension and viral reactivation, especially of varicella zoster and hepatitis B, with thalidomide

Further details are available in the full Safety Update.

**Changes to warfarin dosing at UHS and HHFT**

University Hospital Southampton have changed the timing of warfarin administration for in-patients to 2pm. This has enabled improvement in arrangements for any dosage changes that may be required and has enhanced the continuity of care. The system has been working well since it was introduced a couple of months ago and is set to continue. Hampshire Hospitals are about to introduce the same system.
Patients should revert to the usual 6pm dosing on discharge from hospital and will be counselled to this effect. However, healthcare staff across primary care need to be alert to these changes to help avert any potential for missed doses or double dosing on the day of discharge.

**Dosulepin**

Dosulepin is only licensed for the treatment of depressive illness in adults.
Although it has been shown to be better tolerated than some alternative antidepressants, this is outweighed by the increased cardiac risk and toxicity in overdose. In Clinical Guideline 90, NICE have said that patients should not be initiated on it, or switched to it from other antidepressants.

There is still a significant amount of use across all practices in west Hampshire and prescribers are urged to review any patients who are taking this agent with the aim of gradually stopping treatment or switching to an alternative antidepressant. Any patients at risk of suicide should be assessed urgently.

Dosulepin is contraindicated in patients who have had a recent myocardial infarction and in patients with heart block of any degree or other cardiac arrhythmias. It is also contra-indicated in mania and in severe liver disease.

Treatment should not be stopped suddenly unless serious side effects have occurred as patients may experience unpleasant discontinuation symptoms. Slowly tapering the dose by weekly reductions of 25-50mg can help prevent this. Where an SSRI is indicated, it is suggested that the dose of dosulepin should gradually be reduced to 25-50mg/day and then the SSRI added at the usual starting dose. The remaining dosulepin should then be slowly withdrawn over 5-7 days.

Further information can be obtained from the Medicines Management Team.

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