NHS
West Hampshire
Clinical Commissioning Group

Medicines Optimisation news headlines

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Medicines subject to misuse and particularly dangerous in overdose – Antidepressants, Analgesics and Antiepileptics

Recent case reports and educational sessions have highlighted the potential misuse of a number of medicines. In particular this relates to the three therapeutic areas of antidepressants, analgesics and antiepileptics, there being significant overlap between the agents included in these groups.

With the advent of SSRI antidepressants some of the hazards of the older antidepressants have become less prominent. However a local case review has acted as a reminder that extreme care should be exercised when prescribing tricyclic antidepressants for patients at risk of suicide, due to their cardiotoxicity and epileptogenic effects.

The BNF has the following recommendation:
"There is little to choose between the different classes of antidepressant drugs in terms of efficacy. SSRIs are better tolerated and are safer in overdose than other classes of antidepressant and should be considered first line. Amitriptyline and dosulepin are effective but they are particularly dangerous in overdosage and are not recommended for the treatment of depression."

Information on alternative agents for occasions when an SSRI is not suitable can be found in the Southern Health depression guidelines. Limited quantities of antidepressant should be prescribed at any one time, especially where there is concern about risk of suicide or a past history of overdose.

Where antidepressants and antiepileptics are used for the treatment of neuropathic pain a different issue arises. NICE recommends a choice between amitriptyline, duloxetine, gabapentin and pregabalin (as Lyrica). However gabapentin and especially pregabalin carry a very high potential of abuse for their euphoric properties and should not be used as first line options. They also have the propensity to cause depression of the central nervous system, resulting in drowsiness, headache, sedation, respiratory depression and at the extreme, death. These adverse effects are additive when used with other centrally acting drugs, particularly opioids[2]. In the prison setting such agents have a high commodity value that can put other prisoners at risk of bullying. Such behaviour may not be confined to the prison environment and should be considered within the community as a whole.

Amitriptyline is effective for neuropathic pain, has the advantage of once daily dosing and does not carry the potential for abuse or misuse that has become apparent with the other agents. For these reasons it is the first choice drug after paracetamol when treating this condition. Nortriptyline is not a cost effective choice and consideration should be given to switching patients to amitriptyline.[2] Tramadol may be prescribed to cover a period of acute pain but should never be used for the relief of chronic pain. This guidance is reflected in the updated chronic

pain guidelines for the local healthcare community[1] that will soon be available on the West Hampshire CCG website.

A number of other agents with potential for abuse are currently being monitored by the local prison service and their use is being reduced or discontinued wherever possible. This covers pure analgesics, agents that historically have been prescribed for either analgesia or control of epilepsy and some hypnotics. The main drugs of concerns are tramadol, clonazepam, zopiclone, dihydrocodeine and codeine (including co-codamol, etc.), trazodone and mirtazapine. Further information on the place of these agents in therapy can be found in Safer Prescribing in Prison a joint publication from the Royal College of General Practitioners and the Royal Pharmaceutical Society.

Other useful resources:

1. Chronic non-malignant pain: Guidelines for the pharmacological management of chronic, non-palliative pain in Primary Care / Non-specialist Centres and referral to Specialist Chronic, non-palliative Pain Services, 2016. Basingstoke Southampton and Winchester DPC area
2. PrescQIPP Bulletin 119, January 2016
3. Pain Management Formulary for Prisons

Vortioxetine

NICE TA367, published in November 2015, recommends vortioxetine as an option for treating major depressive episodes in adults whose condition has responded inadequately to two antidepressants within the current episode. This has now been included in the Southern Health Depression Guidelines as in the link overleaf.

Valproate and pregnancy

Some of the dangers of taking valproate preparations during pregnancy have been known for some time, but a review of the recent evidence and data in this area have led to strengthened warnings being issued by the MHRA. Details can be found in the February 2016 edition of Safety Update. The update also provides access to new resources for both healthcare professionals and patients. Although these are mainly aimed at specialist services and should be fully utilised when prescribing of valproate is initiated, they can also be used as an aid during later consultations that might occur in primary care.

Bumetanide – alternative treatment

We have been made aware that there are problems with the availability of bumetanide tablets and that many patients are experiencing difficulty obtaining their usual supply.

Where bumetanide cannot be dispensed prescriptions should be switched to furosemide and local specialists advocate the following dose conversion to achieve a similar therapeutic effect:

1mg bumetanide to 40mg furosemide

As this is not a direct equivalent some people may experience a change in their symptoms. Patients should be advised to contact their GP or Heart Failure Nurse straight away if they suffer any swelling of the legs or an increase in weight.

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