Prescribing and Medicines Optimisation Guidance (2)

Friday 27th March 2020

Response to commonly arising questions regarding

- Anticoagulants - warfarin to DOAC changes
- DMARD risk and frequency of monitoring
- Denosumab administration
- Vitamin B12 administration

Anticoagulants

National guidance concerning the possible transfer of patients who are currently taking warfarin to a DOAC is awaited.
RCGP guidance (https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP%20guidance/202003233RCGPGuidanceprioritisationroutineworkduringCovidFINAL) suggests that some patients could be considered for switching to a DOAC; however this should not be carried out as a matter of course. Suitability for switching should be assessed on a case by case basis and with full knowledge of clinical details such as current creatinine clearance. The anticoagulation service is happy to advise on individual cases if contacted via eRS. Home testing has been raised as an alternative to INR testing in the surgery but is unlikely to be a practical solution unless patients already have their own meter.

DMARDs

The British Society for Rheumatology has produced some Risk Stratification Guides to determine the level of risk for patients taking disease modifying anti-rheumatic drugs or corticosteroids and the consequent level of social distancing that is required.
https://www.rheumatology.org.uk/Portals/0/Documents/Rheumatology_advice_coronavirus_immunosuppressed_patients_220320.pdf?ver=2020-03-22-155745-717
and
https://www.rheumatology.org.uk/Portals/0/Documents/COVID19_risk_scoring_guide.pdf?ver=2020-03-24-171133-657
There haven't been any changes to the recommendations for monitoring and the frequency and range of tests should continue as in current shared care guidance.

Denosumab

Discontinuation of denosumab leads to rapid loss of bone, and increased risk of sustaining multiple vertebral fractures. According to the National Osteoporosis Society, injections may be delayed but it is important that this delay is for no longer than four weeks. The injection does not come in a pre-filled syringe and is therefore not designed for self-administration.

The Metabolic Bone Clinic (Department of Rheumatology) at UHS has issued the following local guidance for patients in their area who receive injections in primary care. It may also be of interest to other areas.

- If practicable, injections should continue, following locally agreed approaches to maximise safety of patients and medical staff. Factors such as age of the patient, presence of serious co-morbidities and ability to visit the surgery, availability of staff and establishing lack of COVID-19 related symptoms for both patient and staff ahead of the appointment, will all be important considerations.
- Where it is judged that the risk of visiting for a denosumab injection is unacceptable, or it is simply not possible to provide the service, oral bisphosphonates or raloxifene should be considered as a temporary replacement for the denosumab therapy. When a patient is switched from denosumab to an oral anti-resorptive, the anti-resorptive should be commenced at around the time the next dose of denosumab would have been given.
- Unless an individual has a specific contra-indication, even if they commenced denosumab following an insufficient response to an oral anti-resorptive, switching denosumab to an oral anti-resorptive, which will at least in part mitigate the resulting bone loss, is definitely preferable to cessation of treatment.
- If neither of these approaches is possible, UHS are happy to discuss the options for individual patients in their area via Advice and Guidance.

Vitamin B12

Replacement vitamin B12 is traditionally administered as an intramuscular injection of hydroxocobalamin, as the injectable route eliminates any problems with gastrointestinal absorption. This route of administration should continue wherever possible with consideration to the factors discussed for denosumab above.

A NICE Clinical Knowledge Summary for anaemia (https://cks.nice.org.uk/anaemia-b12-and-folate-deficiency#!scenarioRecommendation:1) offers oral cyanocobalamin as an alternative where the causes of deficiency is dietary related. The dose is between 50microgram and 150microgram each day.

Where the cause of deficiency is due to other reasons, the effect of cyanocobalamin is less predictable. However the Summary of Product Characteristics for cyanocobalamin states that the tablets can be used for "Treatment of pernicious anaemia when parenteral administration is not possible or not advised."

Cyanocobalamin may be an acceptable alternative for some patients where administration of hydroxocobalamin is not possible or were the potential risk outweighs the expected benefit.

Some stocks of oral cyanocobalamin are available but they are limited. Patients should only be switched from hydroxocobalamin as the need arises.