NHS Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
NHS Portsmouth Clinical commissioning Group
NHS Southampton City Clinical Commissioning Group
NHS West Hampshire Clinical Commissioning Group

Prescribing and Medicines Optimisation Guidance

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1. Methotrexate safe prescribing reminder: Avoid prescribing 10mg tablets

In the UK, it is recommended that, when prescribing oral methotrexate tablets, **only 2.5 mg tablets should be used**; this is to minimise the risk of accidental overdose, which can be fatal. Twenty-one deaths caused by methotrexate poisoning have been reported in England and Wales from 1993 until 2017.

The British Journal of General Practice (BJGP) recently published a cohort study looking at prescribing trends in primary care. (Link) This study shows that breaches of this guidance are common, and vary widely between practices: 9.5% (n = 697) of all practices (n = 7349) give ≥14.3% of their methotrexate as 10 mg tablets; and 1% of practices (n = 66) give ≥52.4% as 10 mg tablets. The authors concluded that the prevalence of unsafe 10mg methotrexate prescribing has reduced but remains common, with substantial variation between practices and CCGs. Anyone can view monthly data on all general practices breaching national methotrexate safety guidance (openprescribing.net/measure/methotrexate), supporting audit and review of current practice.

2. SIGN Guideline 142: Management of osteoporosis and the prevention of fragility fractures. June 2020. (Link)

Revised edition of 2015 guideline addresses:

- Risk factors for fracture (FC)
- Commonly-used tools for assessment of FC risk
- Approaches to targeting therapy
- Pharmacological and non-pharmacological treatments to reduce FC risk
- Treatment of painful vertebral FCs and systems of care.

3. NICE Quality Standard: Renal and ureteric stones (QS195) (Link)

This quality standard covers assessing and managing renal and ureteric stones in children, young people and adults. It describes high-quality care in priority areas for improvement.

4. **Press release: Skin creams dried on fabric can lead to fire deaths. MHRA. 29 July 2020.** (Link)

   MHRA and National Fire Chiefs Council launch a new campaign to raise awareness of fire risk and precautions that need to be taken by users of skin creams.

   Since 2010 more than 50 deaths and serious injuries have been linked to the use of emollient skin creams. MHRA first took regulatory action in 2008 for products containing more than 50% paraffins. In 2018, following new evidence, the MHRA recommended that labelling and product information for a wider range of emollient products (paraffin-based and paraffin-free) should include a warning about the fire hazard, with clear advice not to smoke or go near naked flames and information about the risk of severe burn injury or death when clothing, bedding and dressings with emollients dried on them are accidentally ignited. Since then, these recommendations have been adopted and can be found on products available in the UK.

5. **SPS Advice: What products or interventions are available to aid medication adherence?** (Link)

   Multi-compartment compliance aids (MCCAs) are not the solution to all medication adherence issues and there are risks associated with their use. This resource details what other effective and safe solutions are available for people to use.