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The UKCPA promotes expert practice in medicines management for the benefit of patients, the public and members by establishing standards, workforce development and advancing innovation in all health care settings.

The UKCPA encourages Excellence, Leadership and Partnership

In this issue:

♦ UKCPA Annual Conference announced (page 3)
♦ How to manage dental patients with anticoagulation therapy (page 7)
♦ What’s new in the world of diabetes medicines? (page 10)
♦ Antibiotic prescribing updates (page 12)
♦ How you can support pregnant women with mental health problems (page 14)

Special report:
How much do we know about nefopam: (page 4)
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Please contact us if you need help with setting up your password and getting started. Don’t miss out!
Are you free on Friday 2 November?

We are excited to announce that the date for the **UKCPA annual conference** this year will be Friday 2 November 2018 at the Novotel Hotel in Hammersmith, London.

We are also delighted that we will be hosting the conference **jointly with Pharmacy Management**. Over the last two years we have delivered several extremely successful clinical pharmacy events with Pharmacy Management in the areas of diabetes, respiratory, cardiovascular and biosimilars. The joint conference will build on our partnership and will deliver an exciting, informative and inspiring programme for pharmacy practitioners working in all sectors of practice.

Ted Butler, Chairman of Pharmacy Management agrees: “Pharmacy Management is delighted to build upon the excellent working relationship that has developed between our two organisations. We will be aiming to build on the strong heritage of the UKCPA and bring our support to make this another memorable event.”

The event will bring together the strengths of our two organisations: the clinical expertise of UKCPA and Pharmacy Management’s excellence at delivering outstanding training events. It will also deliver on our shared aim: to provide you with a clinical knowledge and skills based programme, delivered by expert practitioners, that will inform, inspire and support you in your practice. Sharing best practice will be central, so look out for interactive discussions, practical case studies, and research and service improvement posters.

We hope to see you there!
All you need to know about nefopam

Written by Nibras Naji, committee member of the UKCPA Pain Management Group, and pre-operative assessment surgical pharmacist at Northampton General Hospital

We may all have come across the brand name Acupan but do we really know much about nefopam, when it should be used, and the risks associated with it?

Nefopam is a cyclised analogue of the antihistamine diphenhydramine and is a member of the benzoxazocine chemical class due to its ring structure. It is classified as a non-opioid analgesic and being in the same class as paracetamol, it is often presumed to be a simple analgesic as safe to use as paracetamol. The mechanism of action of nefopam is widely unknown although it is considered to act centrally, having some antimuscarinic and sympathomimetic actions.¹

It is totally distinct from other centrally acting analgesics such as morphine and unlike opioids it does not cause respiratory depression. Its peak plasma concentration is roughly one to three hours after dose and its elimination half-life is around four hours.²

Although available in some countries as intravenous or intramuscular preparations, in the UK the only form available is oral tablets.

There are very few studies regarding the potency of nefopam, however one study by Sunshine et al (1975) showed 60mg of nefopam was equivalent to aspirin 650mg, however such doses of aspirin are uncommonly used for pain.

An isolated trial reported nefopam to have an opioid sparing effect of between 20 and 30 percent, with 20mg of nefopam considered to be equivalent to 6-12mg of morphine, although this was using a continuous intravenous infusion.³

For the oral tablets there is little evidence of there being addictive qualities, although an interesting article on nefopam abuse presents case studies of three patients using IM nefopam who developed drug dependence with psycho-stimulant effects.⁴

Where does nefopam fit in the pain ladder?
Being classed as a non-opioid, nefopam technically fits into all stages of the pain ladder. In practice however, it is more commonly used in step 2 or 3 of the ladder, alongside paracetamol and a weak opioid such as codeine. Sometimes it is used more like an adjuvant after neuropathic agents have been initiated.

What is the evidence behind nefopam?
Despite being indicated for acute and chronic pain, including post-operative pain, dental pain, musculoskeletal pain, acute traumatic pain and cancer pain, the evidence base for this is limited.

A 2009 Cochrane review looked at single doses of oral nefopam for acute post-operative pain in adults and found that there was an absence of evidence for the efficacy of nefopam, concluding that its use for this indication is not justified: "Because trials clearly demonstrating analgesic efficacy in the most basic of acute pain studies are lacking, use in other indications should be evaluated carefully".⁵

A SIGN guideline published in 2013 found insufficient evidence to support a recommendation for nefopam to be used in chronic pain, and instead recommended COX inhibitors, NSAIDs and paracetamol before nefopam for patients with non-malignant chronic pain.⁶

¹ Sunshine et al (1975)
² Sunshine et al (1975)
³ Sunshine et al (1975)
⁴ Sunshine et al (1975)
⁵ Sunshine et al (1975)
⁶ Sunshine et al (1975)
Nevertheless, nefopam is used commonly across the UK and is increasingly being prescribed to limit the quantity of opioids patients are using.

Prescribing considerations: things to look out for

Something we should all remember regarding the dosing of nefopam is ‘start low, go slow and review for efficacy’. Not all patients will find benefit from nefopam use so it is essential that efficacy is assessed after 48 to 72 hours to ascertain if treatment should be continued or withdrawn.

The starting dose should be 30mg TDS and titrated upwards, particularly in the elderly who can experience CNS side effects such as confusion and hallucination. The BNF suggests that in adults nefopam can be initiated at 60mg TDS but in practice many adults find benefit from 30mg TDS and using the lowest effective dose for the patient can only be a good thing.

Prescribers often prescribe nefopam like paracetamol, on a ‘when required’ basis. However, the dosing schedule does not recommend this as it is more effective when given regularly.

Nefopam is contraindicated in epilepsy due to its lowering of the seizure threshold. It should also be avoided in patients with a history of seizure activity or those at risk of seizure such as in alcohol withdrawal. It is not suitable for those patients with feeding tubes or swallowing difficulties as when crushed it can cause a local anaesthetic effect. It is also not to be used for patients suffering from pain due to heart attack.

There are many side effects associated with nefopam use. Some common side effects include dry mouth, confusion, nausea, nervousness, light-headedness and urinary retention. It can also colour the urine pink which is a harmless side effect but one that patients should be counselled on.

Other side effects include hypotension, syncope, palpitations, gastrointestinal disturbances (including abdominal pain and diarrhoea), dizziness, paraesthesia, convulsions, tremor, hallucination and angioedema. Less frequently, anaphylactic reactions, coma, vomiting, blurred vision, drowsiness, sweating, insomnia, headache and tachycardia have been reported.

Nefopam’s metabolites can have cross-reactivity with benzodiazepines and can result in false-positives in drugs tests.

Practical aspects

Recently, the price of nefopam has shot up considerably, with a 30mg TDS dose costing around £60 per month. This increase has made it a significant cost to the regions that use it, with many trying to reduce the prescribing and supply, particularly given the questions around efficacy, side effect profile and evidence.

Furthermore, having the uncommon pack size of 90 is something that may be forgotten by individuals. This means that even when given for acute pain or on a when required basis, it is easy to supply a full pack instead of a specified quantity for the duration. Perhaps individuals forget the large pack size and supply a months’ worth of the drug. This can result in patients taking nefopam for longer than intended or having surplus at home that will go to waste.

Like any medicine that is prescribed, deprescribing should take place as appropriate, particularly in the cases where nefopam is required acutely. Although there is potential benefit in its use, nefopam should not be mistaken to be as safe as paracetamol and should not be prescribed as readily as it. Careful consideration should be taken to account for the possible risks associated and its suitability for each patient group.

References


7. NEWT Guidelines. Nefopam monograph. 2017


learni ng events

Learn and connect:

Educational events to support your practice

Diabetes medicines optimisation
(Joint event with Journal of Medicines Optimisation)
15 May 2018: Manchester

Starting out in critical care
15 June 2018: Newcastle

Women’s health: Mind and body
22 June 2018: London

Effective management of patients with gastroenterology and liver conditions
28 June: London

Optimising medicines management in care homes
25 September 2018: London

Advanced Critical Care
28 September 2018: London

Cardiovascular medicines optimisation
(Joint event with Journal of Medicines Optimisation)
2 October 2018: London

What the cell? Unlocking diagnostics, metrics and big data: the new era of stewardship
5 October 2018: Birmingham

UKCPA Annual Conference
(Joint event with Pharmacy Management)
2 November 2018: London

Starting out in critical care
7 December 2018: Merseyside

“The speakers were superb and inspirational, delivering content at exactly the right level for me to understand and learn more.”

Visit www.ukclinicalpharmacy.org/education/events to find out how our learning events can benefit you
Cardiovascular Group news

Helen Williams, Chair of the Cardiovascular Group, discusses ways to manage patients on anticoagulant therapy who are undergoing dental interventions.

When considering whether to continue or stop anticoagulant therapy prior to surgical procedures, two things should be taken into account: Surgical factors, primarily the degree to which the procedure is likely to lead to clinically relevant bleeding; and patient factors, specifically, the bleeding risk factors present for an individual.

Traditionally, dentists have been advised to undertake dental procedures of low and higher risk patients on warfarin, if the INR checked at the time of the procedure is less than four. However, there is less experience in undertaking such procedures on patients taking Direct Oral Anticoagulants (DOACs).

Guidance from the European Heart Rhythm Association (EHRA) includes ensuring any dental procedure is undertaken at trough levels of DOAC.

They highlight that a practical approach may be to schedule the intervention 18 to 24 hours after the last dose, and then restart the DOAC six hours post-procedure. This would mean no interruption in dosing for drugs taken once daily, but skipping a single dose for those taking a twice daily drug.

The patient should remain at the dental practice until bleeding has stopped and be given clear advice on when they should restart their DOAC, usually six hours after the procedure.

The patient should be advised to seek medical advice should significant bleeding occur once DOAC therapy is reinitiated. A tranexamic acid mouthwash may be used to minimise bleeding post-procedure.

The Scottish Dental Clinical Effectiveness Programme (SDCEP) published specific guidance on the management of dental patients taking anticoagulants or antiplatelet drugs in 2015. They recommend that if there is a low risk of bleeding, the procedure should be performed without interruption to the DOAC therapy. However, if there is a higher risk of bleeding, patients should be advised to miss or delay the morning dose of DOAC before treatment.

They also recommend that for all procedures consideration should be given to:
♦ treating early in the day
♦ limiting the initial treatment area and assessing bleeding before continuing
♦ staging extensive or complex procedures
♦ actively considering suturing and packing.

Their advice on restarting DOAC is similar to that of the EHRA.

References


Sharing expertise

Care of the Elderly Group news

Derek Taylor, Chair of the Care of the Elderly Group, summarises key points around deprescribing and reducing falls in older people.

Reducing medicines burden and deprescribing

Deprescribing may be defined as the process of intentionally stopping a medication or reducing a dose to improve the person’s health or to reduce the risk of adverse side effects. Examples of medication that may be considered for deprescribing include antipsychotics, anti-dementia drugs, anticholinergics, NSAID’s, diuretics, inhaled therapies, calcium and vitamin D or oral nutritional supplements.

Consideration may be given to withdrawing a medicine if:

♦ The harm to benefit profile changes significantly
♦ Therapeutic benefits reduce or cease
♦ There are unacceptable side effects
♦ There is continual non-adherence
♦ Age-related changes in physiology
♦ The time to benefit exceeds life expectancy.

Deprescribing should always be undertaken in partnership with the patient and on a trial basis with regular review and symptom monitoring.

Deprescribing tools and models such as Beer’s criteria, START, Medication Appropriateness Index and anticholinergic drug scales can be useful guidance for this process.

Reducing falls and fractures in older people

Whilst evidence suggests that medicines that cause sedation are the most likely to cause falls, many other medicines can contribute to an increased risk of falls such as those that may cause hypotension, bradycardia, hypoglycaemia, drug-induced parkinsonism, blurred vision, cognitive impairment or neuropathy.

As well as a detailed medication review, an optimal assessment of a patient’s risk of falls should involve consideration of many factors such as gait, balance, functional ability, cognitive impairment, cardiovascular issues and continence.

Assessment of osteoporosis risk and treatment is based upon age, sex, risk factors such as previous fractures and falls, low BMI as well FRAX or QFracture scores and bone mineral density values. A daily intake of 700-1200mg of calcium is recommended and post-menopausal women and older men (≥ 50 years) should be considered for colecalciferol therapy, with regular weight-bearing exercise tailored to their abilities.

Oral bisphosphonates should be offered only if the ten-year probability of osteoporotic fragility fractures is at least one percent and IV bisphosphonates are only recommended if the ten-year risk is at least ten percent or if the person has difficulty taking oral bisphosphonates. Those on bisphosphonates should have a regular review of their need for continued treatment.

Taken from presentations delivered by Heather Smith (Reducing falls and fractures in older people) and Helen Whiteside (Reducing medicines burden and deprescribing) at the UKCPA Clinical Pharmacy Training Day in November 2017. Copies of the presentations are available on the members area of the UKCPA website: https://members.ukclinicalpharmacy.org/library/master-classes

Royal Pharmaceutical Society Professional Guidance on Polypharmacy

Christina Short, a member of the Care of the Elderly Group committee, is representing UKCPA on the steering group developing the Royal Pharmaceutical Society guidelines on polypharmacy. The guidance is primarily aimed at pharmacists but can also be used by other health care professionals and organisations.

The guidance has been set out under three key areas:

• Polypharmacy and people
• Polypharmacy and healthcare systems
• Polypharmacy and healthcare professionals

We intend to make sure that UKCPA members have a chance to have their input during the consultation phase, so watch this space.
Community Group news

Gill Hawksworth, Chair of the Community Group, highlights current patient safety initiatives.

There is currently ongoing national work to improve patient safety. This is within the context of several high profile events such as Jeremy Hunt commenting on targeting medication errors in the drive for patient safety and the World Health Organisation (WHO) launching a patient safety challenge in 2017 called ‘Medication without harm’.

The World Health Organisation recognises that medication errors occur when weak medication systems or human factors (such as fatigue, poor environmental conditions or staff shortages) affect prescribing, transcribing, dispensing, administration and monitoring practices, and that this can result in severe harm, disability and even death.

It is expected that patient safety will continue to be an aspect of the Department of Health quality criteria which previously included a written report on patient safety.

It is important that pharmacists are aware of the seven steps to patient safety from the National Patient Safety Agency (NPSA). The first step is to build a safety culture. This is defined as “a culture where individuals and teams have a constant and active awareness of the potential for things to go wrong. It is a culture that is open and fair and one that encourages people to speak up about mistakes”.

The Community Pharmacy Patient Safety Group’s principle wheel is useful as it centres on being open and honest with the key points of report, learn, share, act and review. This is reflected in the Royal Pharmaceutical Society professional standards for reporting, learning, sharing, taking action and review of incidents.

Root cause analysis is a structured approach to investigating incidents and there are several ways to analyse and identify contributory factors. For example, NPSA fishbone diagram that reminds you to look at the various factors which may have contributed to the incident such as patient factors, individual (staff) factors, task factors, communication factors, team factors, education and training factors, equipment and resources, working conditions, organisational and strategic factors.

A CPPE Patient Safety learning campaign ran during March this year and a CPPE focal point workshop is being rolled out nationally which will provide you with all the information to consider these issues and will also provide you with excellent tools and a risk management resource to make sure that patient safety is high on your agenda.

Useful resources

- NPSA seven steps to patient safety
  www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

- Royal Pharmaceutical Society Professional Standards for the reporting, learning, sharing, taking action and review of incidents.
  www.rpharms.com/resources/professional-standards/professional-standards-for-error-reporting

- NPSA root cause analysis
  www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

- CPPE patient safety learning campaign
  www.cppe.ac.uk/patientsafety
New launches and licenses to look out for in 2018

This year will see launches of new biosimilar insulins (a second glargine and also a rapid acting biosimilar) that may mean there is greater pressure to start using these in wider populations to realise the cost-savings seen in other specialities.

Sanofi are due to launch the first SGLT1/2 inhibitor (sotagliflozin) by the end of this year and Novo have a new GLP-1 agonist (semaglutide) that is showing promise in the SUSTAIN trial programme. In addition, there are promises of nasal glucagon coming to market, which may change the way that we treat severe hypoglycaemia.

New licensing also offers exciting possibilities. Both sotagliflozin and dapagliflozin have been trialled in patients with type 1 diabetes and may offer the first licensed adjunctive therapy in this population. There are also be further CV outcome trials being undertaken which will further increase our knowledge and understanding of the use of diabetes medication in CV risk management.

2018 will be interesting, if tricky to keep up with!
Infections of the liver: Key points from the UKCPA Masterclass

The UKCPA recently held a masterclass which was delivered jointly by the Pharmacy Infection Network and the Gastroenterology & Hepatology Group. The strength of the two groups culminated in a day filled with fantastic expert speakers and lively discussions.

Professor John McLaughlan (MRC University of Glasgow Centre of Viral Research) gave an excellent overview of the genetics and mechanism of resistance of the hepatitis C virus and the future problems of resistant patients and their management. This comes at a time when it seems that Sof/Vel/Vox (NICE guidance issued in February 2018) is the last in the DAAs pipeline. We wait with bated breath on the next commissioning of the DAAs which will dictate our future practice in HCV eradication.

Dr Miruna David described the management of hepatic abscesses, their cause and treatments, including drainage and surgery. Some weird and wonderful bugs were mentioned, as were antimicrobial treatments which seemed on the expensive side particularly as extended duration is needed.

This was followed by a presentation on OPAT for skin and soft tissue infections which provided insight, particularly for hepatology specialists, on how to establish community services. Kate Hilditch and Jacob Smiles presented the Manchester model of accessing PWID and how they have started community clinics in different settings.

Interestingly, the team in Manchester based their services on intelligence of where PWID geographically can best be targeted in the Greater Manchester area to base their outreach services.

Sital Shah led us expertly through the viral hepatitis field and presented a case of helminthic infection of the liver that they are currently managing at Kings. Finally, Sarah Cripps put us through our paces in the clinical case workshop on Hepatitis B and D.

If you missed this event, we are delivering a masterclass on 28 June 2018 in London. The day will focus on the clinical management of patients with gastroenterology and liver conditions. A wide variety of gastrointestinal and liver disorders will be covered including celiac disease, inflammatory bowel disease, dysmotility and GI bleed.

The event is suitable for pharmacists who have recently specialised as well as those who are working at a more advanced level. This event would also be very useful overview for pharmacists who work in other specialist areas such as general medicine or surgery and commonly encounter gastroenterology or hepatology patients in their daily practice.

See our website for more details: www.ukclinicalpharmacy.org/education/events/

The ECCO Congress: Sharing evidence and innovation globally

The focus of this year’s European Crohn’s and Colitis Organisation (ECCO) Congress was firmly on science where teams from around the world presented new evidence and interesting innovations.

We heard evidence on inflammatory bowel disease management, understanding the disease and disease patterns, how to target treatment and discussions around whether we should target early disease. Research on the genetics of the disease has not found a reliable pattern, and questions were asked around whether medication targeting different processes of the disease change the pattern of disease and hence the response to consecutive therapies.

Novel treatment strategies were explored such as combinations, stem cells for perianal disease and new drugs such apremilast, a PDE4 inhibitor modulating inflammatory response and cobitolimod, a TLR9 agonist affecting the Th17/T-reg cell response.

A lecture on stress-induced controllers of intestinal inflammation reaction by Hermona Soreq from Israel was very interesting as we know that stress triggers flares. She showed the physical effects of stress on the body and novel potential targets of therapy.

A group from Switzerland presented a model to investigate gut cells by grafting a small section of gut onto the back of mice to investigate the disease process of fistula.

Of particular interest was a talk from Canada on the remote monitoring and the future of ‘telemedicine’ - smart devices controlled remotely by the medical team. The therapy management and monitoring followed treatment algorithms without medical input, which raised the questions of whether the clinician is still needed. Results showed benefits to the clinician, the patients and the commissioners. Is this the future?
Pharmacy Infection Network news

Philip Howard and Emma Cramp, committee members of the Pharmacy Infection Network, provide an update.

Regional Medicines Optimisation Committees

The four Regional Medicines Optimisation Committees (RMOCs) have antimicrobial resistance within their work plan to help support the Government’s ambition to reduce inappropriate antibiotic prescribing by 50 percent by April 2021.

One of their first challenges was how the existing networks support the reduction in inappropriate variation in antimicrobial consumption. This is a radical change as the English AMR and serious infections CQUIN incentive schemes have driven self-improvement, rather than working together to explore and explain local variation.

The Public Health England AMR Fingertips have now introduced hospital type to allow more appropriate benchmarking. More geographical benchmarking will come soon.

There are plans to have whole health economy reporting at an STP footprint in England. To facilitate the RMOCs to disseminate information to antimicrobial teams, NHS Improvement AMR Project Leads are currently mapping all infection related networks in England. This information will be available on the Specialist Pharmacy Service (SPS) website shortly. Further information on the RMOCs can be found at www.sps.nhs.uk/home/networks/

NICE Common Infection Guidelines

NICE have announced that they are developing a series of common infection guidelines over the next three years. The guidelines are for adults and children in hospital, community and primary care settings.

Initially upper respiratory and urinary tract guidelines will be developed. This will be followed by other areas which will be prioritised based on user demand and will include bone and joint, central nervous system, dental, eye, genital, intra-abdominal, lower respiratory tract, sepsis, skin and soft tissue.

So far, acute sinusitis and acute sore throat guidelines have been published, and acute otitis media has been out for consultation. The development programme is quick, with a short four week consultation period. They are being presented as a prescribing table with layers of information below.

With such rapid publication timescales, the challenge will be implementation and how to incorporate them into current guidance. More information can be found here: www.nice.org.uk/guidance/topic/conditions-and-diseases/infections/antibiotic-use#medtech-innovation-briefings

Update to AMR CQUIN for 2018-9 on antimicrobial consumption (for England)

The piperacillin-tazobactam element of the CQUIN is being replaced by a new incentive to increase the proportions of narrow spectrum antibiotics compared to broad spectrum antibiotics. WHO updated the essential medicines list for antibacterials last year. These have been adapted to reflect current UK HCAI and AMR priorities.

There will be three categories (see table below): ACCESS antibiotics are first or second choice antibiotics for common infections. WATCH antibiotics have a higher resistance potential and whose use as first and second choice treatment should be limited to a small number of syndromes or patient groups. RESERVE antibiotics are to be used mainly as last resort treatment options.

RX-info have developed some reports to help monitor these.

Further details can be found at: www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

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**ACCESS**

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**WATCH**

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**RESERVE**

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Respiratory Group news

*Toby Capstick, Chair of the Respiratory Group, reports on the successful Medicines Optimisation in Respiratory workshop run in partnership with the Journal of Medicines Optimisation.*

In February 2018, the UKCPA Respiratory Group held their annual Medicines Optimisation in Respiratory event, in partnership with the Journal of Medicines Optimisation.

For the second year running, the winning combination of UKCPA expert speakers and the logistical team at Pharmacy Management ensured that the event attracted a large turnout of practitioners from all sectors including hospital, CCGs, GP practices and community.

The conference comprised 20 satellite sessions focusing on different aspects of acute illness, chronic disease management, specialised services and professional development, with the aim of developing the knowledge and skills of pharmacists required for the management of respiratory disease in all sectors of practice.

Our expert speakers included hospital practitioners, CCG and community pharmacists, GPs, hospital Consultants, physiotherapists and others, who each contributed to ensuring a successful and engaging conference.

Positive feedback was received from every session, with particular highlights including sessions on asthma, COPD, palliative care and symptom control in respiratory disease, smoking cessation and e-cigarettes, inhaler technique, bronchiectasis, paediatric asthma and viral wheeze, and Interstitial Lung Disease.

Other successful highly specialist sessions included health coaching and motivational interviewing, use of biologics in asthma, listening to chests, and cough.

Ted Butler, Chairman of Pharmacy Management said “feedback from the conference has been excellent and it was a pleasure to see pharmacists so energised and committed to professional development.”

The Respiratory Group Committee would like to thank all our speakers: Darush Attar-Zadeh, Mandeep Butt, Lucy Cave, Toby Capstick, Claire Davidson, Paul Davies, Lynn Elsey, Victoria Evans, Dr Peter George, Richard Goodwin, Professor Adam Hill, Jonathan Laird, Garry McDonald, Helen Meynell, Professor Alyn Morice, Anna Murphy, Sarah Popple, Helena Rosado, Dr Azhar Saleem, and Professor Dave Singh.

I have told all my colleagues about it and would recommend the event to anyone with an interest in respiratory. Loved it!
sharing expertise

Surgery & Theatres Group news

Katharina Floss, Committee member of the Surgery & Theatres Group, reports on her role on the panel of the Royal College of Anaesthetists National Audit Project

The National Audit Projects (NAP) of the Royal College of Anaesthetists (RCoA) are UK wide service evaluations of aspects of safety concern in anaesthesia and have been running since 2003.

Their particular strength lies in the fact that over the years they have achieved an inclusion of all UK NHS hospitals which deliver anaesthetic services.

Previous NAPs which have been covering topics of interest to surgical pharmacists were NAP3 Major complications of central neuraxial blocks and NAP 5 Accidental awareness during general anaesthesia.

NAP3 highlighted ways to reduce harm associated with epidural and spinal anaesthesia and analgesia. NAP5 collected comprehensive data on anaesthetic agents in use at the time and provided recommendations on required monitoring where neuromuscular blockers are used.

The latest, NAP6 Perioperative Anaphylaxis, is due to publish its findings and recommendations this spring. With medicines being a key factor in severe allergic reactions during anaesthesia, the RCoA approached the Royal Pharmaceutical Society for a delegate on the NAP6 steering panel. The RPS then contacted the UKCPA Surgery & Theatres Group to find a pharmacist with knowledge of anaesthetic issues, and Katharina Floss was nominated to be a member of the NAP 6 panel.

The project was conducted truly multi-professionally. It was led by RCoA members and included anaesthetists with a variety of specialist interests from different organisations, along with a number of allergists and immunologists, plus patient group representatives, a governance specialist and an MHRA representative.

NAP6 not only attempted to collect every incident of severe allergic reaction occurring during anaesthesia over a 12-month period in all UK NHS and some private hospitals, but also included a baseline snap-shot audit of all potential allergens administered during surgical procedures in the UK during one week.

This data is about to be published and will form the most comprehensive information of medicines administered in theatres in the UK to date.

The results of the main audit will provide information on the drugs and other substances in use in UK theatres that are most likely to cause a severe allergic reaction.

The full report and recommendations from NAP 6 will be released at its official launch on the 15 May. For details, visit: www.rcoa.ac.uk/research/national-audit-projects

Women’s Health Group news

Christina Nurmahi, Committee member of the Women’s Health Group committee, provides an update on perinatal mental health.

Up to one in five women experience mental health problems during pregnancy or within a year of giving birth, many with no previous history of mental illness.

Twelve percent of women experience depression during pregnancy and 13 percent experience anxiety. Between 15 and 20 percent experience one or both in the first year after childbirth.

The Saving Lives, Improving Mothers’ Care report by MBRACE-UK identified that one-quarter of all maternal deaths between six weeks and one year after childbirth were related to mental health problems, and one in seven of those women died from suicide making it the leading cause of death in pregnancy and up to a year after delivery.

Whilst many are aware of postnatal depression, a range of other mental health conditions may also present during and after pregnancy.

A recently published report by the Royal College of Obstetricians and Gynaecologists, Maternal Mental Health – Women’s Voices, based on a UK survey of over 2000 women who had given birth in the previous five years, highlighted a wide spectrum of mental health illness that may present: low mood, anxiety disorders, depression, obsessive-compulsive disorder, post-traumatic stress disorder, psychosis, as well as more general emotions and symptoms of anger, absent-mindedness, exhaustion and tiredness.

The impact of this is wide ranging, affecting both the woman and her

(Continued on page 15)
family, particularly if left untreated. Overall, 74 percent of the respondents had no previous history of mental health problems, whilst of those who did have a previous history, 95 percent of them went on to experience them during or after pregnancy.

The report highlighted variances in care and inconsistencies in the management of perinatal mental health across the UK. It was apparent from the survey that in women with pre-existing mental health problems, there was no clear consensus from healthcare professionals as to how medication should be managed, and women received varying responses from different professionals.

A number of women were taken off their medication with no alternative treatment or support, with potentially dangerous implications for their mental health and rebound implications for the newborn baby with respect to their care and safety.

Breastfeeding whilst on psychotropic medication also raised significant concerns with many women feeling they were not well supported and received conflicting advice from healthcare professionals.

Good communication between health professionals across the sectors and agreement on management plans will assist in women being better supported. Improving care for these women is a priority.

The UKCPA Women’s Health Group is running a masterclass later this year with a focus on mental health in pregnancy for part of the day.

As pharmacists we play a key role in providing information to other health professionals regarding medication, and are also well placed to inform, advise and allay concerns raised by pregnant women regarding the safety of their medication to their newborn baby.

Do not miss this great opportunity to become further informed about this important topic.

References
