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## Mental Health Edition

### New Lithium Monitoring Standards

NHSGGC has developed new lithium monitoring standards which can be found [here](#).

Lithium is a useful drug, particularly in the maintenance treatment of bipolar affective disorder, recurrent depression and self injurious behaviour. It is widely used and most patients prescribed lithium are in the community. It has a narrow therapeutic index, with a high potential for toxicity and therefore careful monitoring is required for safe use.

Target level for new lithium patients is between 0.6 to 0.8mmol/L.

A lithium level should be taken no earlier than 5-7 days after starting treatment, or changing dose. The level should be a trough i.e. taken approximately 12 hours after the last dose of lithium (In twice daily dosing the morning dose should be withheld until the level has been taken.)

Baseline and ongoing monitoring for lithium therapy should be undertaken according to local NHS GG&C and [national lithium standards](#). Ongoing monitoring should also include:

- **Proactive review of potential interactions**, especially in relation to any medicines that are known to affect renal function or decrease lithium excretion (e.g. NSAIDs, diuretics, ACE inhibitors, angiotensin II receptor antagonists).
- **Regular review of side effects**. Those commonly seen within the therapeutic range include; polyuria, polydipsia, nocturia, diabetes insipidus, metallic taste, fine tremor.
- **Review of potential signs and symptoms of toxicity**. Symptoms of toxicity include:

coarse tremor, muscle twitching or weakness, unsteady gait, GI upset, blurred vision, slurred speech. Toxic effects may develop within the normal range especially in older people.

- **Providing patients with education** necessary to support informed choice and suited to their individual needs.

### MHRA Patient Safety Alert: Valproate and Pregnancy

A recent [MHRA](#) warning highlighted:

- Unborn babies exposed to valproate are at very high risk of neurodevelopment disability and other birth defects.
- Valproate should only be considered for females of, or nearing childbearing potential where other medicines have not been tolerated or are ineffective.
- Where it is necessary for females of, or nearing childbearing to use valproate they should be made aware of the risks, the need for effective contraception planning, and the requirement for specialist oversight if they are planning a pregnancy to allow them to safely change their medication if required.
- If a girl/woman is of, or nearing childbearing potential valproate should be initiated and supervised by a specialist.
- As outlined by MHRA every prescribing clinician is responsible for ensuring communication of risks and support materials to patients; helping them to come to a decision about whether they wish to take valproate and annotating the discussion in the clinical notes. [MHRA advice and support](#).

## Guideline: Clozapine Related Constipation

Clozapine is an effective antipsychotic for treatment of resistant schizophrenia, for use in patients intolerant of other antipsychotics and for the treatment of psychosis in Parkinson's disease. Clozapine-related constipation is very common, affecting up to 60% of individuals. Although rare, death from complications arising from constipation occurs at more than three times the rate of death from agranulocytosis. Severe complications associated with clozapine induced constipation include intestinal obstruction, faecal impaction and paralytic ileus. However, there are no mandatory requirements to monitor patients for, and actively treat, clozapine induced constipation as there are for blood dyscrasias. [Link to GGC Guidelines](#)

### Risk factors for clozapine induced constipation:

- Recent initiation of clozapine (greatest during first four months of treatment, but the risk persists);
- High dose or plasma levels;
- Intercurrent illness;
- History of bowel surgery;
- Concurrent use of other drugs known to cause constipation (opioids, drugs with anticholinergic properties – including treatments for clozapine-induced hypersalivation e.g. hyoscine hydrobromide);
- Lifestyle issues e.g. poor diet and lack of exercise; learning disability; old age; and obesity.

**Patients may not complain about constipation and therefore should be asked regularly about bowel habit.** Tools like the Bristol Stool Chart should be used to help identify constipation. Patients reporting changes in their bowel habit, abdominal pain or having less than 3 bowel movements per week must be considered for a thorough medical assessment including an abdominal examination if necessary. Individuals who currently receive laxative therapy and

continue to report problems with constipation should also be reviewed.

### When clozapine induced constipation has been diagnosed the recommended steps are:

- Changes in lifestyle, diet and fluid intake.
- Consider discussions with mental health team regarding possible clozapine dose reduction.
- Stop or reduce medications that can cause constipation.
- Consider: Macrogol oral powder (laxido) 1–3 sachets daily or lactulose 15ml twice daily. Docusate may be a more acceptable option where concordance is an issue.
- If ineffective, add a stimulant laxative e.g. senna or docusate.
- If severe symptoms emerge e.g. abdominal pain, distension, vomiting, overflow diarrhoea\*, absent bowel sounds, acute abdomen, feculent vomitus or symptoms of sepsis, take the following steps:
  - Stop clozapine and all other antimuscarinic medicines.
  - Refer for emergency medical treatment.
  - Assess for bowel obstruction.

\* It should be remembered that some patients presenting with 'diarrhoea' may in fact be exhibiting overflow and that should be excluded before any treatment is considered.

### Clozapine: 'Out of Practice Drug'

Clozapine's market authorisation imposes strict processes around prescribing and dispensing. Consequently all clozapine prescribing and dispensing is undertaken by secondary care mental health and pharmacy services within NHS GGC. Therefore prescribed clozapine does not routinely appear on the Emergency Care Summary (ECS) which is the 'go to' tool for medicines reconciliation with secondary care. Unfortunately this has led to unintended breaks in clozapine treatment when patients have been admitted to hospital.

In the interests of patient safety and continuity of care, all practices will be contacted via secure email with details of their patients that are

currently prescribed and dispensed clozapine to enable them to update the patient records and add clozapine to the repeat medicines list as an 'out of practice drug' which will show in the patient's ECS. (See: [Adding Medicines to EMIS and VISION that are not to be supplied by GP practices](#)) GPs should be notified via hospital discharge and outpatient letters when patients start or stop clozapine, allowing Emis and Vision to be updated. There will also be an annual update issued in May/June each year to enable prescribing records to be as up to date as possible.

## Guideline: Trazodone Appropriate Formulation Choice and Use

NHS GGC has developed a guideline to assist prescribers in the [appropriate formulation choice and use of trazodone](#) as there has been a **260% increase in the cost of trazodone liquid**. The actual cost has risen by £995k between financial years 2014/15 and 2016/17 despite a 21% drop in the number of patients (355 to 280 patients/month) receiving the liquid formulation.

Due to this substantial increase, ongoing trazodone liquid use should be reviewed on a case by case basis. It may be appropriate to stop the trazodone or change to trazodone capsules. The guideline provides information on opening the capsule and the unlicensed use of its contents.

## Guideline: Reviewing Psychotropic Medicines in Care Homes

This [guidance](#) is intended as a resource to assist medical and non-medical healthcare professionals' decision making process when reviewing psychotropic medicines with care home residents, and where appropriate, their carers and welfare proxies e.g. those with power of attorney regarding health related issues.

The guidance provides non-pharmacological advice on managing symptoms of stress and distress in dementia as well as information on

reviewing antidepressants, antipsychotics, benzodiazepines, cognitive enhancers, mood stabilisers and z-hypnotics.

## Updated Guideline: Depression in Primary Care

This updated [guidance](#) highlights a variety of non-pharmacological and pharmacological options to support people with depression.

**Non-pharmacological information** includes: groups, websites and online cognitive behaviour therapy (CBT), in the printable 'Information websites & telephone numbers' section which patients may find helpful.

**Pharmacological information** highlights;

- Selective serotonin re-uptake inhibitor (SSRI) flat dose response effects; 20's plenty (citalopram, fluoxetine and paroxetine) and 50's enough (sertraline) for the treatment of depression. Higher doses increase adverse effects without greater efficacy.
- Mirtazapine therapeutic dose 30-45mg daily, not 15mg daily which is commonly prescribed.
- Response and efficacy, at a therapeutic dose, is routinely seen within the first 2 weeks of treatment. Where there is a lack of response at 4 weeks, consider reviewing diagnosis, switching antidepressant or increasing dose (remember SSRI dose limitations). The majority of prescribers wait too long, 8-12 weeks, before switching antidepressants or increasing the dose, unfortunately this creates a delay in optimising patient care.
- Links for [switching and stopping](#) antidepressants (see prescribing information).
- Antidepressant consideration for specific patient groups, co-morbidities and managing adverse effects.

## Drug Shortages (Staffnet)

For information on known drug shortages click [here](#). Please contact your local prescribing support team if further information is required.