Area Prescribing Committee Bulletin July 2025

1 - Link to APC website

2 - Link to APC Joint Formulary

Contents

- **New Formulary Submissions and Re-submissions**
- **New and updated Guidelines, Shared Care Protocols and Information sheets**
- **Horizon scanning, formulary amendments and traffic light changes**
- **Publications**
- **Feature of the month**
- **Coming soon**
- **Let us know what you think**

Short on time? Click on the grey square bulletin icon, bottom right of your screen, review the thumbnails and jump to the section you want to read first.

New Formulary Submissions and Re-submissions

Doxylamine / Pyridoxine (Xonvea®) for nausea and vomiting in pregnancy - AMBER 2

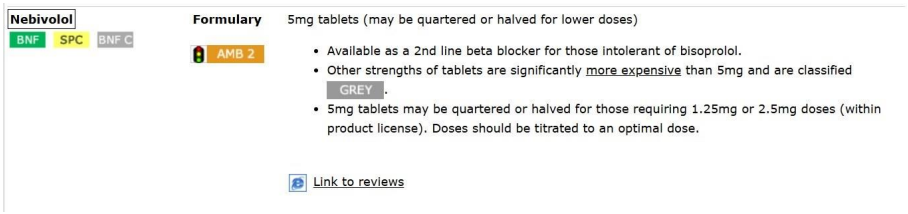
- Licensed treatment option for Nausea and Vomiting of Pregnancy (NVP), but poor published evidence of efficacy and significantly more expensive than other well established treatment options.
- Use is restricted to Specialist initiation for patients with severe hyperemesis that have been reviewed in Secondary Care. May be considered as a second line treatment option when promethazine, cyclizine and prochlorperazine have not been effective or not tolerated.
- Local guidance for Nausea and Vomiting of Pregnancy is available here.

Nebivolol 5mg tablets - *AMBER 2*

Indication and decision:

- Cardio-selective beta blocker for patients intolerant of other beta blockers.
- Usage should be restricted to the 5mg tablet strength as other strengths are significantly more expensive and 5mg tablets are licensed for halving and quartering.

- 1.25mg, 2.5mg and 10mg tablets remain **GREY** ◯
- Patients currently prescribed nebivolol in other strengths to 5mg should be reviewed for a switch to 5mg tablets and up-titration to the maximum tolerated dose. 5mg tablets offer a cost saving opportunity when used in preference to other strengths.



Antipsychotics for chronic or Treatment Resistant Depression -AMBER 2

- Amisulpride may be used as a treatment option for chronic depression . Aripiprazole, olanzapine, risperidone and quetiapine MR are options in Treatment Resistant Depression (TRD).
- Quetiapine MR is licensed for TRD, but this indication is off-label for the other antipsychotics.
- Usage is reflective of current practice and is aligned with NICE guidance. These medicines will be initiated and stabilised in Secondary care mental health services.
- Effective antipsychotic doses for chronic or TRD tend to be lower than those used to treat psychosis and psychotic depression.
- Local Prescribing guidance for antipsychotics has been updated to include this indication.

Atogepant and rimegepant traffic light re-classification - AMBER 2

- For migraine prevention only for patients who have not responded to maximum tolerated dose or are intolerant to at least three standard preventative treatments.
- Can now be initiated in Primary Care on recommendation or Advice & Guidance from the Specialist – does not require a full referral into Secondary Care.
- To continue ongoing prescribing a treatment review is required after 12 weeks of treatment demonstrating efficacy; defined as at least 50% frequency reduction of episodic migraines - atogepant or rimegepant, or 30% of chronic migraines - atogepant only.

📰 New and updated guidelines, Shared Care Protocols and Information Sheets

---

📎Antimicrobial Guidelines:

🚺 Recurrent Urinary Tract Infection (UTI) - **previously known as UTI Prophylaxis guideline - (update)**

The guideline was reviewed cross-referencing the below NICE updates:

- NICE NG112 Urinary tract infection (recurrent): antimicrobial prescribing, last updated Dec 2024.
- NICE CKS Scenario: Recurrent UTI (no haematuria, not pregnant or catheterised), last revised Feb 2025.

Summary of main changes:

- Vaginal oestradiol added as a treatment option and should be considered early in the treatment for peri and post-menopausal women, trans men and non binary people with a female urinary system.
- Methenamine should be offered as an initial alternative to continuous antibiotic therapy for UTI prevention in women, trans men and non-binary people with a female urinary system.
- No change to the antibiotics recommended after trial of methenamine: trimethoprim or nitrofurantoin.
- Post coital antibiotics renamed Single-dose antibiotics.
- Stand-by antibiotics are the last recommended option for limited patients only (fewer than 1 UTI per month and only after sending the sample for cultures).

Summary of Prescribing Strategy Options	
Vaginal Oestrogen	Consider prescribing a vaginal oestrogen in peri- and post-menopausal women, trans men and non-binary people with a female urinary system.
Single-dose Antibiotic (one-off dose)	For rUTIs due to an identifiable trigger (e.g. sexual intercourse)
Continuous Urinary Antiseptic Prophylaxis	Continuous prophylaxis with methenamine hippurate as an initial alternative to continuous antibiotic prophylaxis.
Continuous Antibiotic Prophylaxis	Continuous low-dose antibiotic prophylaxis
Standby Antibiotics	A 'self-start' course of antibiotics if <1 episode per month

Available topical oestrogen options:

Vaginal oestrogen formulation	Dose	Contraindications, cautions and monitoring
Intravaginal creams & gels **Estriol 0.1%** (1mg/g) **cream (preferred strength and most cost-effective option)**	Apply 1 applicatorful daily for 3–4 weeks, then reduced to 1 applicatorful twice weekly, to be applied at bedtime.	• Estriol vaginal cream, Estradiol pessaries or vaginal tablets, and *Estring*® vaginal rig are used for the prophylaxis of recurrent urinary-tract infection in postmenopausal women but are not licensed for this indication. • Ensure prescription is reviewed 12 monthly • Contraindications: ○ Active or recent arterial thromboembolic disease (e.g. angina or myocardial infarction) ○ history of breast cancer, oestrogen-dependent cancer, ○ history of VTE or thrombophilic disorder ○ undiagnosed vaginal bleeding or untreated endometrial hyperplasia • Cautions: see BNF entries for estriol and estradiol.
Vaginal Tablets/Pessaries **Estradiol 10micrograms vaginal tablets** (Prescribe generically. Pessaries are for 2nd line use if vaginal cream isn't suitable.)	10 micrograms daily for 2 weeks, then reduced to 10 micrograms twice weekly.	
Vaginal Ring **Estradiol** 7.5mcg/24hr (Estring®)	To be inserted into upper third of vagina and worn continuously; replace after 3 months.	

Other antimicrobial updates:

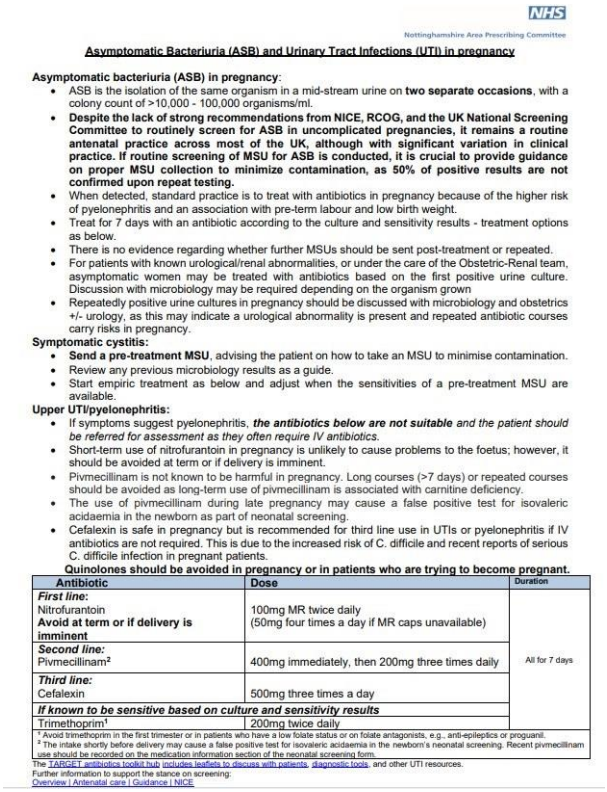
UTI in Pregnancy **(update)**

The guideline was reviewed taking into account the updated NICE CKS Scenario: UTI in pregnancy (no visible haematuria), last updated Feb 2025.

Main changes:

- Changes made to Asymptomatic bacteriuria, with emphasis in education the patients on MSU collection.
- Remember Asymptomatic bacteriuria (ASB) is the **isolation of the same organism** in a mid-stream urine on **two separate occasions**, with a colony count of >10,000 - 100,000 organisms/ml.
- Antibiotic choice and doses remain unchanged.

- Further links added to NICE guidance on antenatal care and Asymptomatic bacteriuria to support the stance on screening.



NHS
Nottinghamshire Area Prescribing Committee

Asymptomatic Bacteriuria (ASB) and Urinary Tract Infections (UTI) in pregnancy

Asymptomatic bacteriuria (ASB) in pregnancy:

- ASB is the isolation of the same organism in a mid-stream urine on **two separate occasions**, with a colony count of >10,000 - 100,000 organisms/ml.
- **Despite the lack of strong recommendations from NICE, RCOG, and the UK National Screening Committee to routinely screen for ASB in uncomplicated pregnancies, it remains a routine antenatal practice across most of the UK, although with significant variation in clinical practice. If routine screening of MSU for ASB is conducted, it is crucial to provide guidance on proper MSU collection to minimize contamination, as 50% of positive results are not confirmed upon repeat testing.**
- When detected, standard practice is to treat with antibiotics in pregnancy because of the higher risk of pyelonephritis and an association with pre-term labour and low birth weight.
- Treat for 7 days with an antibiotic according to the culture and sensitivity results - treatment options as below.
- There is no evidence regarding whether further MSUs should be sent post-treatment or repeated.
- For patients with known urological/renal abnormalities, or under the care of the Obstetric-Renal team, asymptomatic women may be treated with antibiotics based on the first positive urine culture. Discussion with microbiology may be required depending on the organism grown
- Repeatedly positive urine cultures in pregnancy should be discussed with microbiology and obstetrics +/- urology, as this may indicate a urological abnormality is present and repeated antibiotic courses carry risks in pregnancy.

Symptomatic cystitis:

- **Send a pre-treatment MSU**, advising the patient on how to take an MSU to minimise contamination.
- Review any previous microbiology results as a guide.
- Start empiric treatment as below and adjust when the sensitivities of a pre-treatment MSU are available.

Upper UTI/pyelonephritis:

- If symptoms suggest pyelonephritis, ***the antibiotics below are not suitable*** *and the patient should be referred for assessment as they often require IV antibiotics.*
- Short-term use of nitrofurantoin in pregnancy is unlikely to cause problems to the foetus; however, it should be avoided at term or if delivery is imminent.
- Pivmecillinam is not known to be harmful in pregnancy. Long courses (>7 days) or repeated courses should be avoided as long-term use of pivmecillinam is associated with carnitine deficiency.
- The use of pivmecillinam during late pregnancy may cause a false positive test for isovaleric acidaemia in the newborn as part of neonatal screening.
- Cefalexin is safe in pregnancy but is recommended for third line use in UTIs or pyelonephritis if IV antibiotics are not required. This is due to the increased risk of C. difficile and recent reports of serious C. difficile infection in pregnant patients.

Quinolones should be avoided in pregnancy or in patients who are trying to become pregnant.

Antibiotic	Dose	Duration
First line: Nitrofurantoin **Avoid at term or if delivery is imminent**	100mg MR twice daily (50mg four times a day if MR caps unavailable)	All for 7 days
Second line: Pivmecillinam[2]	400mg immediately, then 200mg three times daily	
Third line: Cefalexin	500mg three times a day	
If known to be sensitive based on culture and sensitivity results		
Trimethoprim[1]	200mg twice daily	

[1] Avoid trimethoprim in the first trimester or in patients who have a low folate status or on folate antagonists, e.g., anti-epileptics or proguanil.
[2] The intake shortly before delivery may cause a false positive test for isovaleric acidaemia in the newborn's neonatal screening. Recent pivmecillinam use should be recorded on the medication information section of the neonatal screening form.

The TARGET antibiotics toolkit hub includes leaflets to discuss with patients, diagnostic tools, and other UTI resources.
Further information to support the stance on screening:
Overview | Antenatal care | Guidance | NICE

🦷 Dental Abscess **(update)**

• Reviewed in line with NICE CKS Dental abscess, last reviewed May 2023.

- Stronger emphasis on the need to see a dentist for proper care.
- Antibiotic choice and doses remain unchanged.

Embed://<iframe width="760px" height="500px" src="https://sway.cloud.microsoft/s/32EjHKnpzKrgzh77/embed" frameborder="0" marginheight="0" marginwidth="0" max-width="100%" sandbox="allow-forms allow-modals allow-orientation-lock allow-popups allow-same-origin allow-scripts" scrolling="no" style="border: none; max-width: 100%; max-height: 100vh" allowfullscreen mozallowfullscreen msallowfullscreen webkitallowfullscreen></iframe>

Anticoagulation guidelines - monitoring update

The Anticoagulants in AF and Direct Oral Anticoagulants for DVT and PE - Prescribing Information have both been updated in line with NICE CKS.

- national messages have changed to 4-monthly monitoring in patients over 75 years or with frailty.

- creatinine clearance (CrCl) monitoring intervals have been revised to 15–29 mL/min (from 15-30 mL/min), 30–60 mL/min, and >60 mL/min to better reflect the dosing adjustments required in renal impairment.
- the wording in the guidance has changed to reflect that Apixaban and Rivaroxaban are both the preferred DOACs locally.

Baseline blood tests				
Patient group	U + Es (Creatinine clearance)	Full blood count	Coagulation screen	Liver function tests
All	✓	✓	✓	✓
The current national recommendations, once DOAC treatment is started, are to review patients after 1 month, and at least 3 monthly thereafter. Follow up intervals may vary depending on the individual patient's characteristics, comorbidities and co-medications.[27] **Please see below for frequency on blood monitoring during the first year and ongoing.**				
Patient group	**U + Es (Creatinine clearance)**	**Full blood count**	**Coagulation screen**	**Liver function tests**
Creatinine Clearance **> 60ml/min**	Annually*	Annually*	**X** Inappropriate without correct reagent	Annually*
If the person is frail or older than 75 years[28]	4 monthly**	4 monthly**	**X** Inappropriate without correct reagent	4 monthly**
Creatinine Clearance **30-60ml/min**	Minimum 6 monthly **	Minimum 6 monthly**	**X** Inappropriate without correct reagent	Minimum 6 monthly**
Creatinine Clearance **15-29ml/min**	3 monthly**	3 monthly**	**X** Inappropriate without correct reagent	3 monthly**

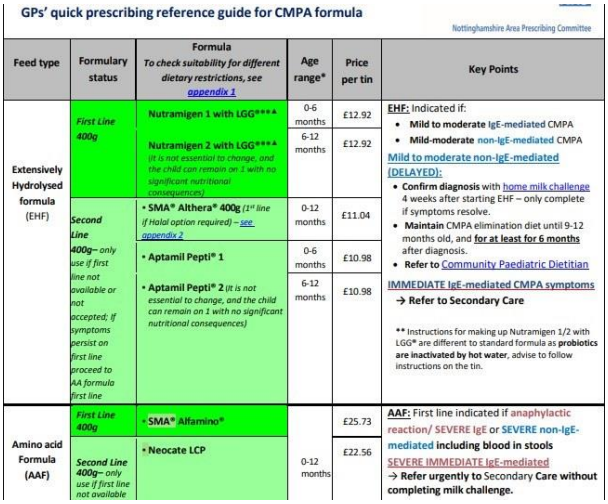
Cow's Milk Protein Allergy (CMPA) in Infants: Healthcare Professional Guidance *(update)*

Appendix 2: Formula suitability for different dietary restrictions

Feed type	Formulary status	Formula	Gluten Free	Lactose Free	Suitable for vegetarians	Halal certified	Kosher certified	Vegan
Extensively Hydrolysed formula (EHF)	*Green 1st choice*	Nutramigen® 1 with LGG®	✓	✓	x	x	x	x
		Nutramigen 2® with LGG	✓	✓	x	x	x	x
	Green 2nd choice	SMA Althera®	✓	x	✓	✓	x[3]	x[4]
		Aptamil Pepti® 1	✓	x	x	x	✓[1]	x
		Aptamil Pepti® 2	✓	x	x[2]	x	✓[1]	x
Amino Acid formula (AAF)	*Green 1st choice*	SMA® Alfamino	✓	✓	✓	✓	✓	X4
	Green 2nd Choice	Neocate LCP	✓	✓	X[7]	✓	x[3]	X[8]
Supermarket dairy milk alternatives		Alpro Soya Growing Up Drink 1-3 + Years	✓	✓	✓	✓	✓	✓
		Alpro Oat Growing Up Drink 1-3 + Years	x	✓	✓	✓	✓	✓
		Oatly Oat Drink Barista Edition	x	✓	✓	x[6]	x[6]	✓
		Oatly Oat Drink Whole	x	✓	✓	x[6]	x[6]	✓

Appendix 1 -Non-IgE and IgE CMPA

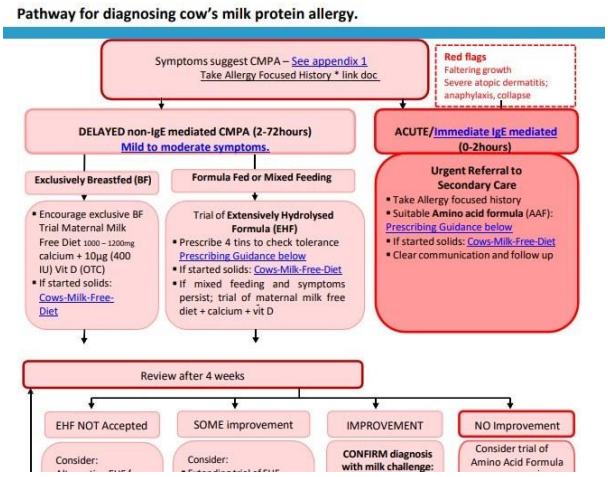
Mild-Moderate non-IgE CMPA	Severe non-IgE CMPA	IgE CMPA
Mostly 2-72 hours after ingestion of cow's milk protein (CMP) Formula fed, exclusively breast-fed or at the onset of mixed feeding. Treatment resistance- Eg atopic dermatitis or reflux, increases the likelihood of allergy.	Mostly 2-72 hours after ingestion of cow's milk protein (CMP). Mostly formula fed, exclusively breastfed or at the onset of mixed feeding. Treatment resistance example atopic dermatitis or reflux, increases the likelihood of allergy	Mostly within minutes (maybe up to 2 hours) after ingestion of cow's milk protein (CMP) Mostly formula fed or at the onset of mixed feeding
(Usually several of the following symptoms) **Gastrointestinal:** • Irritability – colic • Vomiting – reflux – GORD • Food refusal or aversion • Diarrhoea like stools – loose and or more frequent • Constipation – especially soft stools with excessive straining, abdominal discomfort, painful flutters • Blood and/or mucus in stool in other otherwise well infant **Skin:** • Pruritus (itching) • Erythema(flushing) • Nonspecific rashes • Moderate persistent atopic dermatitis	*Severe persisting symptoms of one or more of the following)* **Gastrointestinal:** • Diarrhoea, • Vomiting - *consider FPIES and referral to secondary care* • Abdominal pain • Food refusal or aversion • Significant blood or mucus in stools • Irregular or uncomfortable stools +/- faltering growth **Skin:** • Severe atopic dermatitis +/- faltering growth	*One or more of the following symptoms)* **Gastrointestinal** • Acute vomiting or diarrhoea, abdominal pain/colic. **Skin:** • Acute pruritus, erythema urticaria angioedema • Acute flaring of persisting atopic dermatitis Acute worsening of eczema, **Respiratory:** • acute rhinitis •Difficulty breathing • Swelling -inc facial • Collapse/pallor



GPs' quick prescribing reference guide for CMPA formula

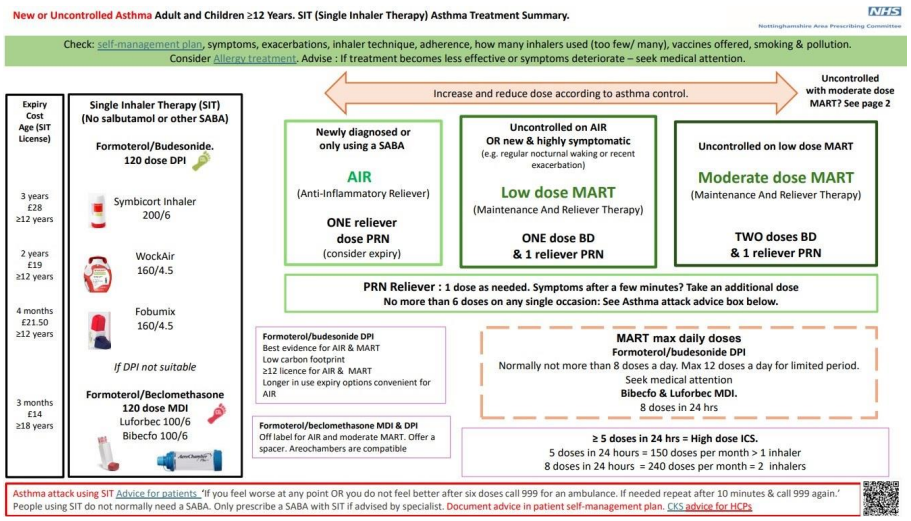
Nottinghamshire Area Prescribing Committee

Feed type	Formulary status	Formula *To check suitability for different dietary restrictions, see appendix 1*	Age range*	Price per tin	Key Points
Extensively Hydrolysed formula (EHF)	*First Line 400g*	Nutramigen 1 with LGG®***	0-6 months	£12.92	**EHF:** Indicated if: • **Mild to moderate** IgE-mediated CMPA • **Mild-moderate** non-IgE-mediated CMPA Mild to moderate non-IgE-mediated (DELAYED): • **Confirm diagnosis** with home milk challenge 4 weeks after starting EHF – only complete if symptoms resolve. • **Maintain** CMPA elimination diet until 9-12 months old, and **for at least for 6 months** after diagnosis. • **Refer to** Community Paediatric Dietitian IMMEDIATE IgE-mediated CMPA symptoms → **Refer to Secondary Care** ** Instructions for making up Nutramigen 1/2 with LGG® are different to standard formula as **probiotics are inactivated by hot water**, advise to follow instructions on the tin.
		Nutramigen 2 with LGG®*** *(It is not essential to change, and the child can remain on 1 with no significant nutritional consequences)*	6-12 months	£12.92	
	Second Line 400g– only use if first line not available or not accepted; if symptoms persist on first line proceed to AA formula first line	• **SMA® Althera® 400g** *(1st line if Halal option required) – see appendix 2*	0-12 months	£11.04	
		• **Aptamil Pepti® 1**	0-6 months	£10.98	
		• **Aptamil Pepti® 2** *(It is not essential to change, and the child can remain on 1 with no significant nutritional consequences)*	6-12 months	£10.98	
Amino acid Formula (AAF)	*First Line 400g*	• **SMA® Alfamino®**	0-12 months	£25.73	**AAF:** First line indicated if **anaphylactic reaction/ SEVERE IgE or SEVERE non-IgE-mediated including blood in stools** SEVERE IMMEDIATE IgE-mediated → **Refer urgently to** Secondary **Care without completing milk challenge.**
	Second Line 400g– only use if first line not available	• **Neocate LCP**		£22.56	



- The updated Cow's Milk Protein Allergy guideline has undergone an extensive review process over the last six months.
- Although no major changes have been made to the guideline, it has been restructured to offer more concise pathways.

Asthma in Adults now renamed ***Nottinghamshire Adult (12 years and older) Asthma Treatment Guideline*** *(update)*



- The guideline is for Adults and Children ≥12 Years, previously it was for 18 and over.
- Updated to reflect NICE guidance on Single Inhaler Therapy (SIT) and Anti-Inflammatory Reliever Therapy (AIR).
- Flow diagrams clarified for AIR and MART regimens.
- **Newly diagnosed patients or patients whose asthma is uncontrolled** with their current regimen, **should be offered (SIT)**.
- A combined inhaled corticosteroid (ICS)/formoterol inhaler (e.g. Fobumix, Symbicort) used either as an 'as-needed reliever' AIR regimen or MART regimen for patients with significant symptoms.
- The guideline includes advice about switching from the previous treatment pathways i.e. regular ICS and plus salbutamol to a MART regimen.
- **If a patient's asthma is controlled, they should continue on their current pathway.**
- **SABA's should no longer be prescribed without an inhaled corticosteroid (ICS)** and that **SABA only patients should be switched to an 'as-needed' single inhaler AIR (anti-inflammatory) regimen**.
- The only inhalers licensed for AIR are budesonide/formoterol dry powder inhalers (DPI).
- Wockair 160/4.5 (160 micrograms of budesonide and 4.5 micrograms of formoterol fumarate dihydrate) has now been added to the guidance and the Joint Formulary. Wockair DPI is licensed ≥12 Years, more cost effective than current formulary options and has a 2-year expiry after opening which would be easier and possibly safer for a patient only using an inhaler occasionally.
- Prescribers reminded to consider inhaler expiry dates to reduce waste

Asthma attack using SIT Advice for patients **'If you feel worse at any point OR you do not feel better after six doses call 999 for an ambulance. If needed repeat after 10 minutes & call 999 again.'**

Managing Behavioural and Psychological symptoms in People with Dementia in Primary Care *(update)*

Dementia with Lewy Bodies (DLB) or Parkinson's Disease Dementia (PDD)

Key Symptom	First Line	Second line
Depression	Watchful waiting, Consult Specialist services, CMHT	Sertraline (4),
Psychosis (2)	Stop dopamine agonists, consider reducing L-DOPA,	Quetiapine (4), Aripiprazole
Aggression	Watchful waiting, Consult Specialist services, CMHT	PRN Lorazepam, Trazodone (6)
Severe Anxiety	Watchful waiting, Consult Specialist services, CMHT	Trazodone (6), Sertraline
Severe Agitation	Watchful waiting, Consult Specialist services, CMHT	PRN Lorazepam, Trazodone (6)
Poor Sleep (3)	Sleep Hygiene & CBT	PRN Zopiclone,
REM sleep behaviour (nightmares, hyperactivity)	Memantine	Clonazepam, Melatonin (7)
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

Alzheimer's Disease

All patients with Alzheimer's, Dementia with Lewy Bodies, Parkinson's disease dementia, and Mixed Dementia should be considered for Acetyl Cholinesterase Inhibitors and/or memantine unless specifically contraindicated, tried and no benefit, or stopped because of adverse effects.

Key Symptom	First Line	Second Line
Depression	Watchful waiting, Consult Specialist services, CMHT	Sertraline
Psychosis (2)	Watchful waiting, Consult Specialist services, CMHT	Aripiprazole, Risperidone (5),
Aggression	Watchful waiting, Consult Specialist services, CMHT	PRN lorazepam (1), Risperidone (5),
Severe Anxiety	Watchful waiting, Consult Specialist services, CMHT	Sertraline, Trazodone (6)
Severe Agitation	Watchful waiting, Consult Specialist services, CMHT	PRN lorazepam, Risperidone (5),
Poor Sleep (3)	Sleep Hygiene & CBT	PRN Zopiclone,
Vocalisation/shouting	Identify underlying symptoms or problems. No specific drug treatment.	
Wandering	No specific drug treatment.	

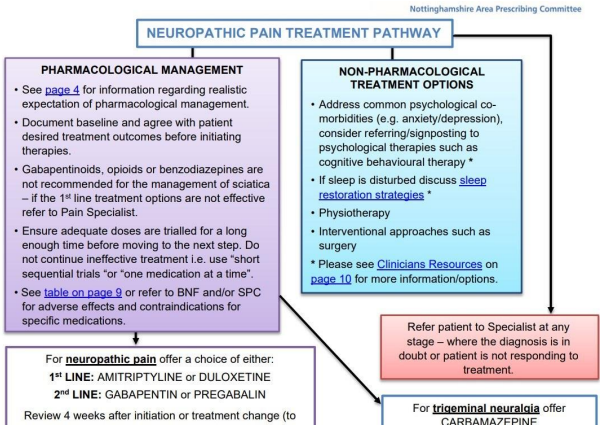
- First-line medication options removed; referral to Community Mental Health Team advised.
- Amisulpiride for agitation and psychosis removed.

- Mirtazapine removed for the treatment of emotional lability and depression in dementia.
- Added acetylcholinesterase inhibitors and/or memantine to be considered for all patients with Dementia with Lewy Bodies, Parkinson's disease dementia, and Mixed Dementia unless specifically contraindicated.
- Added PRN lorazepam for aggression and severe agitation.
- Added trazodone for severe anxiety, agitation and aggression.
- Formulary classifications updated accordingly

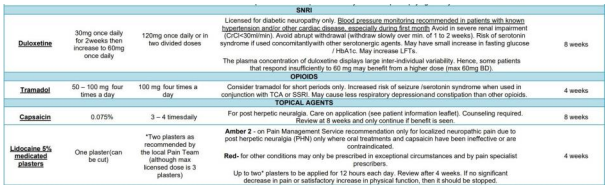
Pain guidelines updates

Management of Neuropathic Pain for Adults in Primary Care (update)

- Gabapentinoids moved to second-line due to safety concerns and to help to reduce the high local prescribing.
- New section added on dose tapering and switching.
- Lidocaine plasters remain under Advice & Guidance.
- CityCare Pain Team to be consulted for final feedback.
- Updated safety advice and added dosing in renal impairment.



Medicine	Typical daily starting dose	Maximum daily dose	Comments	Duration of adequate trial
TRICYCLIC ANTIDEPRESSANTS				
Amitriptyline	10 – 25 mg at night	75 mg at night	Take 90 – 120 minutes before going to bed. Response normally evident at 75 mg daily. Higher doses up to 150 mg only on recommendation from Pain Specialist. Do not stop abruptly – gradually titrate down.	6 – 8 weeks with at least 2 weeks at maximum tolerated dose
Nortriptyline	10 mg at night	75 mg at night	Take 90 – 120 minutes before going to bed. Increase gradually, higher doses to be given under specialist supervision. The dose should preferably be reduced gradually over about 4 weeks. OFF-LABEL USE.	6 – 8 weeks with at least 2 weeks at maximum tolerated dose
ANTIEPILEPTICS				
Carbamazepine	100 mg twice daily	200 mg four times a day	For initial treatment of **trigeminal neuralgia**. Increase slowly to 200mg 2-4 times daily. Avoid sudden withdrawal - gradually titrate down.	6 – 8 weeks with at least 2 weeks at maximum tolerated dose
Gabapentin	300 mg at night	600 mg three times a day	See page 7 for suggested titration regimen. NICE CKS rapid titration is less preferred locally. Side effects worst at times of dose increase. Do not stopabruptly – gradually titrate down.	3 – 8 weeks for titration plus two weeks at maximum dose
Pregabalin	75mg twice daily	300mg twice daily	Only if gabapentin ineffective or not tolerated. See page 7 - for suggested titration regimen. NICE CKS rapid titration is less preferred locally. Do not stop abruptly –gradually titrate down.	4-6 weeks
SNRI				

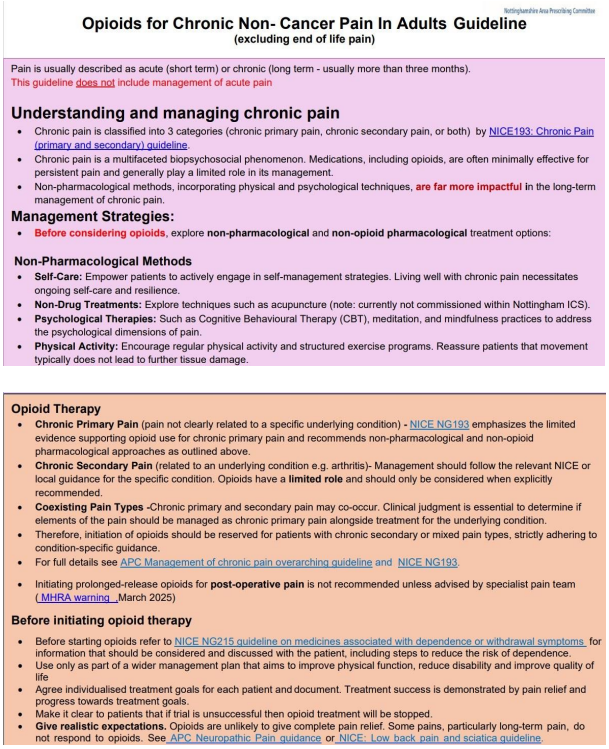


SNRI				
Duloxetine	30mg once daily for 2weeks then increase to 60mg once daily	120mg once daily or in two divided doses	Licensed for diabetic neuropathy only. Blood pressure monitoring recommended in patients with known hypertension and/or other cardiac disease, especially during first month. Avoid in severe renal impairment (CrCl<30ml/min). Avoid abrupt withdrawal (withdraw slowly over min. of 1 to 2 weeks). Risk of serotonin syndrome if used concomitantly with other serotonergic agents. May have small increase in fasting glucose / HbA1c. May increase LFTs. The plasma concentration of duloxetine displays large inter-individual variability. Hence, some patients that respond insufficiently to 60 mg may benefit from a higher dose (max 60mg BD).	8 weeks
OPIOIDS				
Tramadol	50 – 100 mg four times a day	100 mg four times a day	Consider tramadol for short periods only. Increased risk of seizure /serotonin syndrome when used in conjunction with TCA or SSRI. May cause less respiratory depression and constipation than other opioids.	4 weeks
TOPICAL AGENTS				
Capsaicin	0.075%	3 – 4 timesdaily	For post herpetic neuralgia. Care on application (see patient information leaflet). Counseling required. Review at 8 weeks and only continue if benefit is seen.	8 weeks
Lidocaine 5% medicated plasters	One plaster(can be cut)	*Two plasters as recommended by the local Pain Team (although max licensed dose is 3 plasters)	**Amber 2** - on Pain Management Service recommendation only for localized neuropathic pain due to post herpetic neuralgia (PHN) only where oral treatments and capsaicin have been ineffective or are contraindicated. **Red-** for other conditions may only be prescribed in exceptional circumstances and by pain specialist prescribers. Up to two* plasters to be applied for 12 hours each day. Review after 4 weeks. If no significant decrease in pain or satisfactory increase in physical function, then it should be stopped.	4 weeks

Opioids for Chronic Non- Cancer Pain In Adults Guideline (excluding end of life pain)

(update):

- Fully revised to reflect NICE guidance prioritising non-opioid and non-pharmacological options.
- Dosing table redesigned to avoid linear escalation.



Nottinghamshire Area Prescribing Committee

Opioids for Chronic Non- Cancer Pain In Adults Guideline
(excluding end of life pain)

Pain is usually described as acute (short term) or chronic (long term - usually more than three months).
This guideline does not include management of acute pain

Understanding and managing chronic pain

- Chronic pain is classified into 3 categories (chronic primary pain, chronic secondary pain, or both) by NICE193: Chronic Pain (primary and secondary) guideline.
- Chronic pain is a multifaceted biopsychosocial phenomenon. Medications, including opioids, are often minimally effective for persistent pain and generally play a limited role in its management.
- Non-pharmacological methods, incorporating physical and psychological techniques, **are far more impactful** in the long-term management of chronic pain.

Management Strategies:

- **Before considering opioids**, explore **non-pharmacological** and **non-opioid pharmacological** treatment options:

Non-Pharmacological Methods

- **Self-Care:** Empower patients to actively engage in self-management strategies. Living well with chronic pain necessitates ongoing self-care and resilience.
- **Non-Drug Treatments:** Explore techniques such as acupuncture (note: currently not commissioned within Nottingham ICS).
- **Psychological Therapies:** Such as Cognitive Behavioural Therapy (CBT), meditation, and mindfulness practices to address the psychological dimensions of pain.
- **Physical Activity:** Encourage regular physical activity and structured exercise programs. Reassure patients that movement typically does not lead to further tissue damage.

Opioid Therapy

- **Chronic Primary Pain** (pain not clearly related to a specific underlying condition) - NICE NG193 emphasizes the limited evidence supporting opioid use for chronic primary pain and recommends non-pharmacological and non-opioid pharmacological approaches as outlined above.
- **Chronic Secondary Pain** (related to an underlying condition e.g. arthritis)- Management should follow the relevant NICE or local guidance for the specific condition. Opioids have a **limited role** and should only be considered when explicitly recommended.
- **Coexisting Pain Types** -Chronic primary and secondary pain may co-occur. Clinical judgment is essential to determine if elements of the pain should be managed as chronic primary pain alongside treatment for the underlying condition.
- Therefore, initiation of opioids should be reserved for patients with chronic secondary or mixed pain types, strictly adhering to condition-specific guidance.
- For full details see APC Management of chronic pain overarching guideline and NICE NG193.
- Initiating prolonged-release opioids for **post-operative pain** is not recommended unless advised by specialist pain team (MHRA warning March 2025)

Before initiating opioid therapy

- Before starting opioids refer to NICE NG215 guideline on medicines associated with dependence or withdrawal symptoms for information that should be considered and discussed with the patient, including steps to reduce the risk of dependence.
- Use only as part of a wider management plan that aims to improve physical function, reduce disability and improve quality of life
- Agree individualised treatment goals for each patient and document. Treatment success is demonstrated by pain relief and progress towards treatment goals.
- Make it clear to patients that if trial is unsuccessful then opioid treatment will be stopped.
- **Give realistic expectations.** Opioids are unlikely to give complete pain relief. Some pains, particularly long-term pain, do not respond to opioids. See APC Neuropathic Pain guidance or NICE: Low back pain and sciatica guideline.

Other guidelines

Male Lower Urinary Tract Symptoms (LUTs):

- Tadalafil 5mg daily added for patients with LUTS and erectile dysfunction.
- PSA monitoring guidance clarified.
- Doxazosin removed.

Osteoporosis and fracture prevention guideline for Primary Care in Nottinghamshire

(minor update)

- Renal referral removed for patients with CrCl <30 mL/min who require bone sparing therapy.
- These patients should now be referred to Bone Health Specialist, Healthcare of Older People, or Metabolic Medicine.

Medicines Initiated or Recommended by Out of Area (OOA) Clinicians (update)

- Minor changes circulated via email and approved post-meeting.

Vitamin B12 guidelines (update)

- IM hydroxocobalamin remains the preferred treatment for most vitamin B12 deficient patients.
- Self-administration of IM injections is promoted.
- Oral hydroxocobalamin added as an option for certain deficiency types and re-classified as AMBER 3.

Horizon scanning, formulary amendments and traffic light changes

- **Survimed®** OPD 1.5kcal – Changed from GREY to AMBER 3 in line with updated guidance for management of PERT shortage. This is a temporary reclassification in line with Vital 1.5cal® and Peptisip Energy HP®, to be reviewed once the shortage improves - **AMBER 3** 🟠
- **Medihoney** CE marked products - All Medihoney products except for the MediHoney barrier cream, have been discontinued due to the inability to comply with regulatory stipulations. **GREY** ⚪**.** They will be replaced by Activon tube, Algivon and Actilite- **AMBER 2** 🟠
- **Suvexx®**sumatriptan 85 mg/ naproxen 457 mg film-coated tablets – Not a cost-effective combination product . **GREY** ⚪
- **Rivaroxaban** oral suspension 5 mg/ml – **GREY** ⚪ **-** Potential risk for medication errors from availability of alternative strength to that currently in use for paediatric patients (1mg/ml).
- **Liraglutide generics** for Type 2 diabetes - **AMBER 2** 🟠 Zegluxen® and Diavic® are preferred brands locally. Significantly less expensive than other GLP-1 agonists.

Publications

3 - Link to APC webinars

Update on Our Webinars and Bulletin Format

Dear colleagues,

After carefully reviewing attendance at previous webinars and considering our current team capacity, we've decided to pause our live webinar sessions for the time being.

Instead, we'll be focusing on enhancing our bulletin. We've heard your feedback that previous versions felt too streamlined and that simply linking to updated documents didn't always make it easy to spot what had changed. In response, we're aiming to make the bulletin more detailed and informative, highlighting key updates more clearly and, where helpful, including recorded audio or video content for more complex topics or those with broader impact.

We hope this new approach will make it easier for you to stay informed and engaged.

As always, we welcome your thoughts and suggestions—please don't hesitate to get in touch at nnicb-nn.nottsapc@nhs.net.

Warm regards,

The Interface Team

4 - Link to APC podcasts

🎧 **Our new episode is here:** Gabapentinoids – Prescribing and Deprescribing

Our latest podcast episode, *Gabapentinoids: Prescribing and Deprescribing*, is a rich and thought-provoking discussion hosted by **Nirlas Bathia**, Medicines Optimisation Pharmacist.

Joining the conversation are:

- **Dr Stephen Willott**, GP at the Windmill Practice and GP Alcohol Specialist for NRN,
- **Dr Jonathan Lloyd**, GP at Tudor House Medical Practice with 15 years' experience working in prison healthcare,
- **Purba Bhattacharjee**, Clinical Lead at Nottingham City Pain Clinic,
- **Dr John Barker**, Clinical Lead for Nottinghamshire Healthcare Substance Misuse Services.

Together, they explore the complexities of gabapentinoid use, challenges in deprescribing, and practical insights from both primary and secondary care perspectives.

Feature of the month: Prescribing Weight Management Injectables – Tirzepatide (Mounjaro®)

From **23rd June 2025**, prescribing of weight management injectables such as tirzepatide will be managed by a **community-based, locally commissioned service**: the **Nottingham and Nottinghamshire Weight Management Single Point of Access (WMSPA)**.

This service will support a **limited cohort of patients** who meet the defined local eligibility criteria. All referrals must be submitted via WMSPA, which will coordinate access and, where appropriate, refer patients on to other relevant services.

Referral forms and further information are available here and on Teamnet.

Tirzepatide should not be prescribed by GPs for weight loss.

Please note: The WMSPA service is not yet fully launched but is currently accepting referrals.

🗓️ Coming Soon - APC work programme July 2025

APC work programme July 2025:

- Aminosalicylates in IBD in Adults - Information Sheet
- NICE TA 1075: Dapagliflozin for treating chronic kidney disease - Update
- Management of CKD in adults guidelines - Update following NICE TA1075: Dapagliflozin for treating CKD
- SGLT2 inhibitors in CKD and Type 2 Diabetes pathway -Update following NICE TA1075: Dapagliflozin for treating CKD
- Midodrine Prescribing Information Sheet - Update
- Salbutamol Inhaler Prescribing in Adults and Children ≥ 12 years with Asthma – New
- Continence Formulary- Update
- Antimicrobial guidelines: Acute sinusitis - update; Chronic bacterial sinusitis - update; Diagnosis of UTI- Quick reference guide- proposal to retire; Scabies – interim update; Tuberculosis - update; Clostridioides Difficile- minor update.

Let us know what you think!

The work of the Nottinghamshire Area Prescribing Committee is supported and managed by the interface team.

We can be contacted via

📧 Email: nnicb-nn.nottsapc@nhs.net

🌐 **Visit:** Nottinghamshire APC Website

📄 **View: Meeting Minutes, Bulletins, Formularies on Teamnet**