

Inflammatory Bowel Disease – Mercaptopurine Shared Care Protocol		
V1.0	Last reviewed: 21/03/2024	Review date: March 2027

National shared care protocol adapted for local use:

Inflammatory Bowel Disease: Mercaptopurine for patients within adult services (non-transplant indications)

As well these protocols, please ensure that [summaries of product characteristics](#) (SPCs), [British national formulary](#) (BNF) or the [Medicines and Healthcare products Regulatory Agency](#) (MHRA) or [NICE](#) websites are reviewed for up-to-date information on any medicine.

Specialist responsibilities

- Assess the patient and provide diagnosis; ensure that this diagnosis is within the scope of this shared care protocol ([section 2](#)) and communicated to primary care.
- Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and provide the appropriate counselling (see [section 11](#)) to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet.
- Assess for contraindications and cautions (see [section 4](#)) and interactions (see [section 7](#)).
- Conduct required baseline investigations and initial monitoring (see [section 8](#)).
- Initiate and optimise treatment as outlined in [section 5](#). Once the patient is known to be tolerating the medicine, transfer to shared care would normally take place. It is expected that at least one hospital review will occur before transfer to shared care occurs. Transfer to primary care is normally after the patient has been treated for 3 months and has had satisfactory investigation results for at least 4 weeks.
- If shared care is considered appropriate, and once treatment is optimised, write to the patient's GP practice, and request shared care; detailing the diagnosis, the current and ongoing dose, baseline, and most recent test results, confirm the monitoring schedule and when the next monitoring is required. Include the specialist service contact information ([section 13](#)).
- The specialist should also provide the details of the treatment to be undertaken by the GP. Including the reasons for the choice of treatment, medicine combination, frequency of treatment, and the next review date by the specialist.
- Prescribe sufficient medication to enable transfer to primary care (usually 12 weeks), including where there are unforeseen delays in transfer of care. Further prescriptions will be issued if, for unforeseen reasons arrangements for shared care are not in place. Patients should not be put in a position where they are unsure where to obtain supplies of their medication. The specialist team will be responsible for monitoring and prescribing the medicine during this initial period.
- Conduct the required monitoring in [section 8](#) and communicate the results in writing to primary care within 14 days, where possible. After each review, provide primary care with a written summary within 14 days, advising whether treatment should be continued, confirming the ongoing dose, and whether the ongoing monitoring outlined in [section 9](#) remains appropriate.

- Give advice to primary care on continuing treatment if a woman becomes or wishes to become pregnant or breastfeed.
- Provide advice to primary care on the management of adverse effects if required.
- Review patients annually. Review once every two years if patients under a [Patient Initiated Follow-ups \(PIFU\) pathway](#).
- Provide the patient with a patient information sheet and details of their treatment, including any dosage changes made, follow-up appointments, monitoring requirements, and specialist team contact details. Highlight the importance of monitoring the patient and explain the potential withdrawal of treatment if monitoring appointments are not attended.

Primary care responsibilities

- If shared care is not accepted, inform the specialist of the decision in writing within 14 days with reasons as to why shared care cannot be entered into. If shared care is accepted, ensure knowledge and understanding of the therapeutic issues relating to the patient's clinical condition. Undergo any additional training necessary to carry out the prescribing and monitoring requirements.
- Agree that, in their opinion, the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within the secondary care.
- If accepted, prescribe ongoing treatment as detailed in the specialist's request and as per [section 5](#) taking into account any potential drug interactions in [section 7](#).
- Adjust the dose of mercaptopurine prescribed as advised by the specialist and communicate any changes made to the patient.
- Conduct the required monitoring as outlined in [section 9](#). Communicate any abnormal results to the specialist.
- Ensure the patient is given the appropriate follow-up and monitoring appointments. If a patient fails to attend, contact the patient in a timely manner to arrange alternative appointments. It is the GP's responsibility to decide whether to continue treatment in a patient who does not attend follow-up and monitoring appointments. If the patient regularly fails to attend the monitoring appointment, the GP may withhold the prescription and inform the consultant responsible for the patient's care.
- Assess for possible interactions with mercaptopurine when starting new medicines ([section 7](#)).
- Manage any adverse effects as detailed in [section 10](#) and discuss them with the specialist team when required. Refer the patient back to the specialist team if further investigation is required.
- Stop mercaptopurine and discuss urgently with the specialist if bone marrow suppression is suspected.
- Discuss other adverse effects with the specialist team as clinically appropriate ([section 10](#)).
- Contact the specialist team for advice if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist.
- Contact details for primary care prescribers will be made available.
- Offer patients vaccination in line with the current Joint Committee on Vaccination and Immunisation advice. ([Immunisation against infectious disease](#)).

Patient and/or carer responsibilities

- Take mercaptopurine as prescribed and do not stop taking it without speaking to their primary care prescriber or specialist.
- Tell anyone who prescribes them a medicine that they are taking mercaptopurine.
- Attend regularly for monitoring and review appointments, routine influenza and pneumococcal vaccinations with primary care and specialist. If unable to attend any appointments, they should inform the relevant practitioner as soon as possible and arrange an alternative appointment. Be aware that medicines may be stopped if they do not attend appointments.
- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in [section 11](#).
- Report the use of any over the counter (OTC) medications to their prescriber and be aware they should discuss the use of mercaptopurine with their pharmacist before purchasing any OTC medicines.
- Store the medication securely away from children.
- Read the information supplied by the GP, specialist, and pharmacist, and contact the relevant practitioner if they do not understand any of the information given.
- Inform the specialist or primary care prescriber as soon as possible if they become pregnant or wish to become pregnant.

Community pharmacist responsibilities

- The community pharmacist will professionally check prescriptions to ensure they are safe for the patient and contact the GP if necessary.
- Fulfil the legal prescriptions unless they are considered unsafe.
- Counsel the patient on the proper use of their medication.
- Advise patients suspected of experiencing an adverse reaction with their medicines to contact their GP.

1. Background

[Back to top](#)

Mercaptopurine is an immunosuppressant anti-metabolite used either alone or, more commonly, in combination with other agents (usually corticosteroids) to influence the immune response. Therapeutic effect may be evident only after weeks or months and can include a steroid sparing effect, thereby reducing the toxicity associated with high dosage and prolonged usage of corticosteroids.

Azathioprine is generally the immunosuppressant of choice, but if azathioprine treatment fails, its active metabolite mercaptopurine may be tolerated.

Mercaptopurine is not licensed for all the conditions it is used to treat, as noted below. However, its use for the indications below is established and supported by various sources and bodies including the BNF, NICE, British Society of Gastroenterology (BSG).

This shared care protocol applies to adults aged 18 and over.

2. Indications

[Back to top](#)

Licensed indications vary with the brand. See the relevant summary of product characteristics ([see SPC](#)) for full details.

The specialist must specify the indication for each patient when initiating shared care and clearly state when the use is off label.

3. Locally agreed off-label use

[Back to top](#)

Maintenance of acute Ulcerative Colitis and Crohn's disease.

4. Contraindications and cautions

[Back to top](#)

This information does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it. Please see [BNF](#) & [SPC](#) for comprehensive information.

Contraindications:

- Known hypersensitivity to the active substance or any excipients.
- Absent or very low thiopurine methyltransferase (TPMT) activity – risk of life-threatening pancytopenia.

Cautions:

- Live vaccines (e.g., oral polio, oral typhoid, MMR, BCG, yellow fever): should be avoided in patients taking mercaptopurine greater than 1.5 mg/kg/day. Please refer to the [Green Book Chapter 6](#) for current advice regarding the use of live vaccines in patients taking immune modulators. Please discuss with specialist team before vaccines are administered. N.B. Routine influenza and pneumococcal vaccinations are highly recommended with a single pneumococcal booster after 5 years.
- Patients with active/history of pancreatitis.
- Concomitant prescribing of allopurinol or febuxostat. see [section 7](#).
- Patients receiving mercaptopurine are at an increased risk of developing lymphoproliferative disorders and other malignancies, notably skin cancers, sarcomas, and uterine cervical cancer in situ. Exposure to sunlight and UV light should be limited and patients should wear protective clothing and use a sunscreen with a high protection factor to minimise the risk of skin cancer and photosensitivity.
- Patients with low thiopurine methyltransferase (TPMT) activity are at increased risk of myelosuppression. Substantial dose reduction is generally required.
- Severe infection, including hepatitis B or C and history of tuberculosis.
- Severely impaired hepatic or bone marrow function.
- Pregnancy and breastfeeding (see [section 12](#)).
- Patients who have no history of exposure to varicella zoster virus (VZV) i.e., chickenpox or herpes zoster (shingles), should avoid contact with individuals with chickenpox or herpes zoster. Contact the on-call microbiologist via the hospital switchboard for advice regarding those who have no antibodies to varicella–zoster virus and who have had significant

exposure to chickenpox or herpes zoster. See [The Green Book– chapter 34](#) for detailed guidance. If the patient is infected with VZV, appropriate measures should be taken, which may include antiviral therapy and supportive care.

- Patients' heterozygote for TPMT – use with caution due to increased risk of toxicity. The Gastroenterology Specialist Team will recommend increased monitoring if necessary.

Treatment may need to be monitored more frequently in the following:

- Elderly patients
- Impaired renal function. Dose reduction may be required in moderate or severe renal impairment ([CrCl](#) <50ml/min). Please discuss with the gastroenterology specialist team.
- Mild/moderately impaired hepatic function
- Mild/moderately impaired bone marrow function

5. Initiation and ongoing dose regimen

[Back to top](#)

- Transfer of monitoring and prescribing to primary care is normally after at least 3 months, and when the patient dose has been optimised and with satisfactory investigation results for at least 4 weeks.
- The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability. Treatment is usually continued for a minimum of 2 years if there is a good clinical response. Mercaptopurine has a cumulative action, and a clinical improvement can take up to 3 to 4 months.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.
- Termination of treatment will be the responsibility of the specialist.

Initial stabilisation:

There is a wide dose range depending on the indication. The selected dose will be tailored to the individual patient and decided by the specialist.

The initial stabilisation period must be prescribed by the initiating specialist.

The duration of treatment will be determined by the specialist based on clinical response and tolerability.

Maintenance dose (following initial stabilisation):

Mercaptopurine is given orally as a single daily dose.

The maximum dose is 100mg daily. Smaller doses are often effective (1-1.5mg/kg per day).

A conversion factor of approximately 0.5 can be used when equating azathioprine doses to 6-mercaptopurine, i.e., 1-1.5mg/kg/day or tolerated dose.

Some patients may respond to lower doses.

The initial maintenance dose must be prescribed by the initiating specialist.

Conditions requiring dose adjustment:

Lower doses may be required if there is significant renal or hepatic impairment, in elderly patients, and in patients with mild/moderately impaired bone marrow function, TPMT deficiency or NUDT15 mutation ([see SPC](#)).

6. Pharmaceutical aspects

[Back to top](#)

Route of administration:	Oral
Formulation:	Mercaptopurine 50mg tablets Mercaptopurine 20mg/ml oral suspension (Xaluprine®) Mercaptopurine 10mg tablets (unlicensed import)
Administration details:	<p>The tablets should be swallowed whole and not split / crushed. Can be taken either with or without food, but patients should standardise which method is chosen. Tablets should be taken at least 1 hour before or 2 hours after milk or dairy products.</p> <p>Taking with or after food may relieve nausea, however the oral absorption of mercaptopurine may be reduced. Consideration should be given to monitoring therapeutic efficacy more closely if patient is taking mercaptopurine consistently with food.</p> <p>For mercaptopurine oral suspension, the bottle should be shaken vigorously for at least 30 seconds to ensure the suspension is well mixed.</p>
Other important information:	<p>Mercaptopurine is cytotoxic. It is recommended that it is handled following local recommendations for the handling and disposal of cytotoxic agents.</p> <p>Mercaptopurine tablets and oral suspension are not bioequivalent with respect to peak plasma concentration; increased haematological monitoring is advised if switching between formulations.</p> <p>When prescribing mercaptopurine, remain vigilant with regards to the similarity in name with mercaptamine.</p>

7. Significant medicine interactions

[Back to top](#)

The following list is not exhaustive. Please see [BNF](#) or [SPC](#) for comprehensive information and recommended management.

The following drugs must not be prescribed without consultation with the specialist:

- **Allopurinol** has the potential to cause thiopurine toxicity and should be avoided, except with specialist input.
- **Febuxostat** has the potential to cause thiopurine toxicity; avoid in combination with mercaptopurine.
- **Live vaccines** (e.g., oral polio, oral typhoid, MMR, BCG, yellow fever) can be given to patients on stable long term low dose corticosteroid therapy (defined as ≤ 20 mg prednisolone per day for >14 days) alone or in combination with low dose non-biological oral immune modulating drugs (e.g., mercaptopurine up to 1.5mg/kg/day). Clinician discretion is advised. Please refer to the [Green Book Chapter 6](#) for current advice, and advice for patients taking higher doses.
- **Warfarin** – thiopurines may reduce anticoagulant effects of warfarin. Consider increasing the dose of the anticoagulant and monitor closely.

- **Phenytoin, sodium valproate, carbamazepine** absorption may be reduced by mercaptopurine.
- **Co-trimoxazole / trimethoprim** – Prolonged courses (>4 weeks) of co-trimoxazole and trimethoprim should be used with caution – can cause life threatening haematotoxicity. (Note: occasionally, some patients are on co-trimoxazole for special circumstances. E.g., PCP prophylaxis)
- **Clozapine** - avoid due to increased risk of agranulocytosis.
- **Aminosalicylates** (sulfasalazine, mesalazine or olsalazine) - increased risk of haematological toxicity with concomitant thiopurine due to TPMT inhibition. Dose adjustment and additional monitoring of FBC may be required.

The following drugs may be prescribed with caution:

- **ACE inhibitors** - increase the risk of anaemia and or leukopenia.
- **Cimetidine and indomethacin** - concomitant administration of thiopurines may increase the risk of myelosuppression.

8. Baseline investigations, initial monitoring, and ongoing monitoring to be undertaken by specialist

[Back to top](#)

Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in the immediate future will prescribing and monitoring be transferred to primary care.

Baseline investigations:

- Height and weight
- Blood pressure
- Full blood count (FBC)
- Urea and electrolytes (U&Es) & creatinine clearance (CrCl)
- Alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST), and albumin
- Baseline thiopurine methyl transferase (TPMT) status
- Screening for viral infections as per local policy, e.g., HIV, hepatitis B and C, varicella zoster, Epstein Barr virus, cytomegalovirus
- Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case-by-case basis.
- Confirm cervical screening is up to date.
- Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g., pneumococcal, shingles, influenza, COVID-19)

Initial monitoring and at dose change:

To be repeated every 2 weeks until the dose has been stable for 6 weeks, then monthly for 3 months, and then 3 monthly thereafter.

- FBC
- U&Es, including creatinine and CrCl.
- LFTs, including AST and/or ALT, and albumin.

Following a dose increase repeat every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule. More frequent monitoring is appropriate in patients at higher risk of toxicity.

Ongoing monitoring:

The specialist will retain the responsibility for monitoring the patient’s ongoing response to treatment and advise if a dose change or treatment cessation is appropriate. **This should usually be undertaken annually.**

Measurement of TPMT status, specifically 6-TGN and 6-MMPN, should be considered when reviewing perceived inefficiency, dose changes and side effects (particularly cytopenia’s and hepatotoxicity). Such levels ~~are an accurate and reliable~~ can guide the need for a dose adjustment.

After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 9](#) remains appropriate.

9. Ongoing monitoring requirements to be undertaken by primary care

[Back to top](#)

See [section 10](#) for further guidance on management of adverse effects/responding to monitoring results.

Monitoring and actions	Frequency
<ul style="list-style-type: none"> FBC U&Es including creatinine and CrCl. ALT and/or AST, and albumin 	<p>Monthly for three months, unless already completed in secondary care. Thereafter at least every 12 weeks, and more frequently in patients at higher risk of toxicity, as advised by the specialist team.</p> <p>The exact frequency of monitoring to be communicated by the specialist in all cases.</p>
<ul style="list-style-type: none"> Patients aged from 50 years who are severely immunosuppressed and have not received the shingles vaccine before will be eligible for the shingles vaccine (varicella zoster). This will be provided as two doses of the non-live vaccine. If patient is taking additional DMARDs, check advice for all drugs. Please refer to Green Book Chapter 6 and Chapter 28a (Shingles) for further details. Annual influenza (The Green Book, Chapter 19) vaccinations are highly recommended 	<ul style="list-style-type: none"> Shingles vaccination: Chapter 28a (Shingles). Influenza vaccination: annual. It is advisable to add the patient to the influenza vaccine list. Other vaccinations as per national schedule, e.g., pneumococcal vaccine (single booster after 5 years), COVID-19.

<ul style="list-style-type: none"> • COVID-19 vaccination is safe and recommended (see The Green Book, Chapter 14a). • Repeat pneumococcal vaccine may be indicated. See Green Book Chapter 25 for advice. 	
<p>(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.</p>	
<p>10. Adverse effects and other management Back to top</p> <p>Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit www.mhra.gov.uk/yellowcard</p> <p>For a full list of side effects and information on incidence of ADRs, refer to the BNF or see relevant summaries of product characteristics.</p> <p>IF YOU ARE IN ANY DOUBT ABOUT ANY POTENTIAL ADVERSE REACTION, PLEASE CONTACT THE GASTROENTEROLOGY SPECIALIST TEAM.</p>	
<p>Result</p>	<p>Action for primary care</p>
<p>As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance.</p> <p>Other benchmark values may be set by secondary care in specific clinical circumstances. This will be communicated by the specialist.</p>	
<p>Full blood count:</p> <ul style="list-style-type: none"> • White blood cells less than $3.5 \times 10^9/L$ • Lymphocytes less than $0.5 \times 10^9/L$ • Neutrophils less than $1.6 \times 10^9/L$ • Platelets less than $140 \times 10^9/L$ • Eosinophilia greater than $0.5 \times 10^9/L$ 	<p>If neutrophils are 1 or less, stop mercaptopurine, contact patient to safety net and retest in a week. Specialist team to decide on treatment plan on restarting.</p> <p>all others discuss urgently with specialist team and consider interruption.</p> <p>NB - Isolated lymphopenia or eosinophilia is often a feature of the underlying autoimmune indication and is rarely an indication to discontinue azathioprine/mercaptopurine.</p>
<p>Mean cell volume >105 fl.</p> <p>NB: Reversible, dose-related increases in mean corpuscular volume are a known effect of thiopurines.</p>	<p>Consider withholding treatment if there is a significant increase from baseline.</p> <p>Check serum folate, B12, alcohol history and TSH and treat any underlying abnormality. If results of these additional investigations are normal discuss with specialist team urgently.</p>

Signs or symptoms of bone marrow suppression, e.g., unexplained bleeding or bruising with or without sore throat, mouth ulcers	Consider withholding treatment. Check FBC immediately and discuss with the specialist team. See haematological monitoring above.
Infections: Infection requiring antibiotics	Temporarily withhold thiopurine until the patient has recovered. Consider additional investigations (e.g., FBC), if clinically appropriate.
Liver function tests: <ul style="list-style-type: none"> ALT or AST >100 units/L, or any sudden increases (e.g., double of baseline), OR Unexplained fall in serum albumin <30g/L (in the absence of active disease) Jaundice 	Consider withholding. Discuss with specialist team. When used for hepatology indications, continue treatment, and discuss with specialist urgently. Check any other reason for risk of hepatic dysfunction such as alcohol history and drug interactions, including OTC or complementary medication.
Renal function: Creatinine rise >30% over 12 months, or calculated GFR reduces to <60ml/min	Withhold and discuss with specialist team
Gastrointestinal disorders: Nausea	Review for reversible causes. Ensure patient is taking tablets with food or continue drug with split dosing. In some individual, nausea will normally resolve after a few days. If troublesome prescribe antiemetic . If recurs, then withhold until discussed possible dose reduction with gastroenterology specialist team.
Suspected pancreatitis	Withhold and discuss with specialist team.

11. Advice to patients and carers

[Back to top](#)

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:

- Signs or symptoms indicating haematological toxicity, e.g., sore throat, infection, unexplained or abnormal bruising or bleeding.
- Signs or symptoms of pancreatitis, e.g., abdominal pain, nausea, or vomiting.

- Signs of symptoms of hepatic toxicity, e.g., jaundice (yellowing of the skin or whites of the eyes)

The patient should be advised to:

- That mercaptopurine should not be taken with dairy products (at least 1 hour before or 2 hours after milk or dairy products).
- During a serious infection mercaptopurine should be temporarily discontinued until the patient has recovered from the infection.
- That vaccination in line with current national advice (e.g., for COVID-19, influenza) is safe and recommended.
- Tell anyone who prescribes them a medicine that they are taking mercaptopurine. Always ask a pharmacist before purchasing any medicines over the counter, including herbal remedies, and ask if they are safe.
- To inform their specialist or primary care prescriber promptly if pregnancy occurs or is planned.
- All women aged 25-64 years old should be encouraged to participate in national cervical cancer screening programmes. There is no need to attend more frequently than recommended.
- Patients have a small increased risk of skin cancers so should be advised to wear high factor sunscreen and to wear a hat and protective clothing when in strong sunshine. Sun beds should be avoided. Patients should be advised to carry out regular self-examination of the skin and report if there are any new lesions and/or changes to skin.
- Patients taking mercaptopurine should be advised to avoid contact with people with chicken pox or shingles and report any such contact urgently to their primary care prescriber. If the patient is exposed, contact the specialist for advice. For detailed advice on risk assessment and post exposure prophylaxis following exposure to chicken pox and shingles, see:
 - the [Green Book \(Chapter 34\)](#)
 - UKSHA guidance: [Guidelines on post exposure prophylaxis \(PEP\) for varicella/shingles April 2022](#)

Patient information:

- [Crohn's and Colitis UK](#)

12. Pregnancy, paternal exposure, and breast feeding

[Back to top](#)

It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.

All patients should be informed of the risks and benefits of taking this medicine during pregnancy and breastfeeding. The specialist team should be contacted if a patient becomes pregnant or is planning to become pregnant or breastfeed.

Pregnancy:

Current available data does not suggest that mercaptopurine exposure during pregnancy increases the risk of miscarriage, congenital malformation, intrauterine death, foetal growth

restriction, or preterm delivery but the data are limited for some outcomes. A careful assessment of risk versus benefit should be made before mercaptopurine is prescribed to patients who are pregnant.

Information for healthcare professionals: [Mercaptopurine in pregnancy \(Bumps\)](#)

Information for patients and carers: [Mercaptopurine in pregnancy \(Bumps\)](#)

Breastfeeding:

If mercaptopurine is used, monitor infant's blood count and liver function.

Information for healthcare professionals: <https://www.sps.nhs.uk/medicines/mercaptopurine/>

Paternal exposure:

Mercaptopurine is compatible with paternal exposure. There is currently no evidence of adverse foetal effects relating to paternal use.

Information for healthcare professionals: [Paternal Exposure](#)

13. Specialist contact information

[Back to top](#)

Please contact the appropriate IBD Nurse Specialist if you require any advice about treatment or disease management.

Nottingham University Hospitals NHS Trust Contacts:

Switchboard **0115 9249924 ext. 78715**

IBD Direct line **0115 9709324**

Sherwood Forest NHS Foundation Trust Contacts:

Kings Mill Hospital 01623 622515

IBD Nurse Specialists **Ext 2501**

Out of hours

A consultant, specialist registrar or pharmacist may be contacted via the appropriate hospital switchboard.

14. Additional information

[Back to top](#)

Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient's GP or their contact details.

15. References

[Back to top](#)

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- NICE Guidance: Crohn's disease: management (NG129) May 2019. Accessed via: <https://www.nice.org.uk/guidance/ng129>
- NICE Guidance: Ulcerative colitis: management (NG130) May 2019. Accessed via: <https://www.nice.org.uk/guidance/ng130> on 09/12/21

16. Other relevant national guidance

[Back to top](#)

- Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from <https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/>
- NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from <https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/>
- General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care>
- NICE NG197: Shared decision making. Last updated June 2021. <https://www.nice.org.uk/guidance/ng197/>.

17. Local arrangements for referral

[Back to top](#)

Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.

- The request for shared care should be accompanied by individual patient information, outlining all relevant aspects of the patient's care and which includes direction to the shared care protocols on the [APC website](#).
- Prescribing and monitoring responsibility will only be transferred when it is agreed by the specialist and the patient's primary care prescriber that the patient is stabilised on their medication regimen without adverse effect and with benefits demonstrated.
- The specialist will request shared care with the GP in writing.
- If the GP doesn't agree to shared care, they should inform the specialist of their decision in writing within 14 days, outlining the reason for the decline. The agreement can be assumed if the GP does not provide a written decline.
- In cases where shared care arrangements are not in place or where problems have arisen within the agreement, and patient care may be affected, the responsibility for the patient's management, including prescribing, reverts back to the specialist.
- Should the patient's condition change, the GP should contact the relevant specialist using the details provided with the shared care request letter.