

NEWSLETTER

Supporting the Derbyshire Health Community

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Happy New Year to all our readers

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JAPC Update

The Joint Area Prescribing Committee (JAPC) is a countywide group covering Derbyshire County PCT and Derby City PCT. It provides recommendations on drugs and medicines management issues. RED drugs are those where prescribing responsibility would normally lie with a hospital consultant or a specialist. AMBER drugs are those that although usually initiated within a hospital setting, could appropriately become the responsibility of the GP. This would normally be under a shared care agreement. GREEN drugs are regarded as routine for primary care prescribing. BROWN drugs are those that JAPC does not recommend for use (DARK BROWN) or only in restricted circumstances (LIGHT BROWN) due to lack of data on safety, effectiveness, and/or cost-effectiveness.

The most recent updates are in the table below:

Drug	Date considered	Decision
Apraclonidine eye drops	January 2008	RED
Cabergoline (hyperprolactinaemia only)	January 2008	LIGHT BROWN
Co-proxamol (unlicensed)	January 2008	DARK BROWN
Ezetimibe	January 2008	LIGHT BROWN
Fostair	January 2008	LIGHT BROWN
Hedrin lotion	January 2008	GREEN
Omalizumab	January 2008	RED
Sativex (unlicensed)	January 2008	DARK BROWN
Duodopa (co-careldopa 5/20 intestinal gel)	December 2007	DARK BROWN
Erdosteine	December 2007	DARK BROWN
Exenatide	December 2007	LIGHT BROWN
Glatiramer acetate	December 2007	RED

Use of Varenicline

Varenicline is now approved as a first line option for smoking cessation, with behavioural support, in discussion with client and clinician. Varenicline was first marketed in the UK in December 2006 and since then its safety has been monitored closely by the Medicines Healthcare products Regulatory Agency (MHRA) in conjunction with the European Medicines Agency (EMA).

Recently concerns have arisen about reports of suicidal thoughts and behaviour reported in association with the use of varenicline and these data have been subject to Europe wide review. Following the most recent consideration of the available data it has been recommended that the product information for varenicline for

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doctors and clients should be updated to contain warnings that depression has been reported in patients who are trying to stop smoking using varenicline and that the symptoms of this depression may include suicidal thoughts and behaviours.

The EMEA advises that:

- Doctors are already aware of the risk of using varenicline in patients who have an underlying mental illness. They also need to be aware of the possibility that patients who are trying to stop smoking can develop symptoms of depression, and they should advise their patients accordingly.
- Patients who are taking varenicline and develop suicidal thoughts should stop their treatment and contact their doctor immediately.

UK licence for co-proxamol now withdrawn

The MHRA has issued a position statement on the sale and supply of co-proxamol following the cancellation of the marketing authorisations (MAs) at the end of 2007. The agency states that no further stock should be released into the normal distribution chain by manufacturers or their agents after 31 December 2007.

However, the agency states that following withdrawal of the MAs, it will remain legal to continue to supply co-proxamol released into the normal distribution chain prior to 31 December 2007 up until the product expiry date on the label has passed. To ensure any surplus stock is removed from the market once the MAs have been withdrawn, the MHRA has asked manufacturers to make a voluntary withdrawal of stock and put in place arrangements to receive returned stock from both wholesale distributors and pharmacies (both community and hospital).

The agency adds that it recognises there is a small group of patients who are likely to find it very difficult to change from co-proxamol or where alternatives appear not to be effective or suitable, and so for this group, following cancellation of the licences at the end of 2007, there is a provision for the supply of unlicensed co-proxamol on the responsibility of the prescriber.

When a licensed drug is prescribed the drug company is responsible for litigation resulting from adverse consequences, assuming it was prescribed appropriately. With an unlicensed drug the legal responsibility lies with the prescriber. If co-proxamol is to be prescribed now that it is no longer licensed then it is advised that the prescriber makes every effort to inform the patient of safety concerns, to obtain informed consent, and to document this in the notes. **Co-proxamol is classified as DARK BROWN in Derbyshire.**

In the January 2008 Drug Tariff the basic price of 100 co-proxamol tablets is now £20.36, up from £2.79!

Safety warning for fentanyl patches

The US Food and Drug Administration have issued an updated safety warning on the use of fentanyl patches (Durogesic). The FDA states that they have continued to receive reports of deaths and life-threatening side effects after doctors have inappropriately prescribed the patch or patients have incorrectly used it¹.

According to the report, doctors are prescribing the product inappropriately for patients for indications such as headaches, relief of pain after surgery, and in patients who are opioid-naïve. Additionally, patients are inappropriately using the product by applying more patches than prescribed, or changing the patches more frequently than appropriate, or applying heat to the patch, all resulting in dangerously high fentanyl levels in the blood.

In its Public Health Advisory and Health Care Professional Sheet, the FDA has stressed the following safety information (taken directly from source):

- Fentanyl patches are only for patients who are opioid-tolerant and have chronic pain that is not well controlled with other pain medicines. The patches are not to be used to treat sudden, occasional or mild pain, or pain after surgery.
- Healthcare professionals who prescribe the fentanyl patch, and patients who use it, should be aware of the signs of fentanyl overdose: trouble breathing or slow or shallow breathing; slow heartbeat; severe sleepiness; cold, clammy skin; trouble walking or talking; or feeling faint, dizzy, or confused. If these signs occur, patients should get medical attention right away.
- Patients prescribed the fentanyl patch should tell their doctor, pharmacist and other healthcare professionals

about all the medicines that they take. Some medicines may interact with fentanyl, causing dangerously high fentanyl levels in the blood and life-threatening breathing problems.

- Patients and their caregivers should be told how to use fentanyl patches. This includes instructions on how often to apply the patch, reapplying a patch that has fallen off, replacing a patch, and disposing of the patch
- Heat may increase the amount of fentanyl that reaches the blood and can cause life-threatening breathing problems and death. Patients should not use heat sources such as heating pads, electric blankets, saunas, or heated waterbeds or take hot baths or sunbathe while wearing a patch. A patient or caregiver should call the patient's doctor right away if the patient has a temperature higher than 102 degrees while wearing a patch.

1. <http://www.fda.gov/bbs/topics/NEWS/2007/NEW01762.html>

Escitalopram for depression

The Mental Health Services Drugs and Therapeutics Committee have reviewed the evidence for the use of escitalopram for their service. They reached the conclusion that this drug would not be made routinely available from the Mental Health Teams. They found a lack of compelling evidence to support the claims that escitalopram is more effective, or has a faster onset of action than citalopram in depression. Consequently, escitalopram is not included in the Derbyshire Prescribing Guide. This approach is fully supported by the Derbyshire Mental Health Services NHS Trust.

We have been made aware that the expenditure on this drug has reached £187,684 in our local health community over the last twelve months. The equivalent cost with citalopram would be £16,017; that is a potential saving of **£171,667 pa**. The Mental Health Services Trust would like to encourage primary care not to routinely use this medicine. The savings generated from this could be used to invest in other much-needed health services across Derbyshire.

Contributed by Dr M G Jackson, Consultant Psychiatrist and Chair Drugs and Therapeutics Committee, Derbyshire Mental Health Services NHS Trust.

Escitalopram has always been classified as DARK BROWN in Derbyshire and is not recommended for use.

Key point: escitalopram is a DARK BROWN drug – use citalopram.

Drug safety update

'Drug Safety Update' is only available electronically and you can register for e-mail alerts. It can be found at www.mhra.gov.uk/mhra/drugsafetyupdate These are some of the highlights from the December issue:

Rosiglitazone and pioglitazone: cardiovascular safety

Key message:

Rosiglitazone and pioglitazone should not be used in people with heart failure or history of heart failure; incidence of heart failure is increased when rosiglitazone or pioglitazone are combined with insulin. Closely monitor patients during treatment for signs and symptoms of fluid retention, including weight gain or oedema. Rosiglitazone might be associated with a small increased risk of cardiac ischaemia, particularly in combination with insulin; rosiglitazone should be used in patients with previous or current ischaemic heart disease only after careful evaluation of individual risk.

Advice for healthcare professionals:

- Rosiglitazone and pioglitazone should not be used in people with heart failure or history of heart failure (ie, New York Heart Association class I-IV)
- Incidence of heart failure is increased when rosiglitazone or pioglitazone is combined with insulin
- People who are at particular risk of heart failure should start rosiglitazone or pioglitazone at the lowest available dose; any dose increase should be done gradually
- Patients should be monitored closely during treatment for signs and symptoms of fluid retention, including weight gain or oedema
- Treatment should be stopped if any deterioration in cardiac status occurs

Dosulepin: measures to reduce risk of fatal overdose

Key message:

Dosulepin has a small margin of safety between the (maximum) therapeutic dose and potentially fatal doses. Use in new patients should be avoided; where necessary, only specialist-care prescribers should start treatment for patients who have not previously received dosulepin, and prescribers should limit the amount

issued per prescription. To reduce the risk of fatal overdose, dosulepin has been available only in child-resistant blister packs since November 2007.

Advice for healthcare professionals:

- Initiation of treatment for patients who have not previously received dosulepin should be restricted to specialist-care prescribers
- A limited number of tablets should be prescribed to reduce the risk of overdose for all patients, especially those at risk of suicide
- A maximum prescription equivalent to 2 weeks' supply of 75 mg per day should be considered in patients with increased risk factors for suicide at initiation of treatment, during any dose adjustment, and until improvement occurs
- Concomitant medicines that may increase the risk of toxicity associated with dosulepin should be avoided
- There is no immediate need to change treatment for established patients
- Patients should be advised to store tablets securely, out of sight and reach of children
- In cases of overdose, patients should seek immediate medical attention

ACE inhibitors and angiotensin II receptor antagonists: not for use in pregnancy

Key message:

ACE inhibitors and angiotensin II receptor antagonists should not be used at any stage of pregnancy. Use in women who are planning pregnancy should be avoided unless absolutely necessary, in which case the potential risks and benefits should be discussed.

Advice for healthcare professionals:

Patients who are planning pregnancy:

- Unless continued treatment with an ACE inhibitor or angiotensin II receptor antagonist is considered essential (e.g. in some patients with hypertension and diabetic nephropathy), women who are planning pregnancy should be switched to alternative antihypertensive treatments that have an established safety profile for use in pregnancy.
- The balance of risks and benefits of continued treatment with an ACE inhibitor or angiotensin II receptor antagonist versus the potential risk of congenital anomaly should be discussed with the patient.

Patients who are pregnant:

- On diagnosis of pregnancy, treatment with an ACE inhibitor or angiotensin II receptor antagonist should be stopped as soon as possible, and, if appropriate, alternative treatment should be started.

ACE inhibitor, diuretic and NSAID: a dangerous combination

The following article is taken from the Australian Adverse Drug Reactions Bulletin produced by the Adverse Drug Reactions Advisory Committee (ADRAC).

The control of hypertension by ACE inhibitors and diuretics and their beneficial effects in heart failure are antagonised by NSAIDs. Concurrent use of NSAIDs and diuretics is associated with a twofold increase in the risk of hospitalisation for heart failure compared with diuretics alone.¹ Moreover, ACE inhibitors, NSAIDs and diuretics, individually or in combination, are involved in over 50% of cases of iatrogenic acute renal failure reported to ADRAC. More specifically, the combined use of ACE inhibitors, diuretics and NSAIDs, termed the "triple whammy", is implicated in a significant number of reports to ADRAC of drug-induced renal failure.² This effect is also seen with COX-2 inhibitors and angiotensin receptor antagonists ("sartans").³ Most reports to ADRAC of drug-induced renal failure relate to elderly patients, and this applies as well to renal failure associated with the triple therapy (median age 76 years). The fatality rate for ADRAC cases of renal failure with the "triple whammy" is 10%.

The use of ACE inhibitors and angiotensin receptor antagonists is increasing, as is the use of these agents in combination products with a diuretic. Episodes of renal failure appear to be precipitated by mild stress (e.g. diarrhoea, dehydration) in a patient taking the triple combination or by the addition of a third drug (usually an NSAID) to the stable use of the other two. ADRAC suspects that the risk of acute renal failure is underestimated and the syndrome under recognised.

ADRAC wishes to remind prescribers that the combination of ACE inhibitors (or angiotensin receptor antagonists), diuretics and NSAIDs (including COX-2 inhibitors) should be avoided if possible, and great care should be taken with ACE inhibitors and NSAIDs in patients with renal impairment.

1. Arch Intern Med 1998; 158:1108-12 2. MJA 2000; 172:184-5 3. MJA 2000; 173:274 (corr. MJA 2000; 173:504).

Community acquired pneumonia – diagnosis and referral

CAP is an important healthcare concern. The overall mortality from CAP is 5 -10%, so it is important to identify and treat patients with this disease. Not everyone with LRTI will have pneumonia. One primary care study in the UK showed that only 40% of patients with new lower respiratory tract symptoms and focal chest signs had radiological evidence of pneumonia.⁴

Differentiating between acute bronchitis and CAP

	Acute bronchitis	Community-acquired pneumonia
Description	Inflammation of the trachea and major bronchi	Inflammation of the lower respiratory tract, with exudate filling lung tissue and obstructing airways
Prevalence	44 cases per 1,000 adults	5 -11 cases per 1,000 adults
History	Cough with or without sputum, wheeze or breathlessness	Cough with at least one other symptom of sputum, wheeze, dyspnoea or pleuritic pain
Examination	Wheeze often present but no other focal chest signs Sweats, fever, muscle pain and raised temperature may or may not be present.	Focal chest sounds present. At least one symptom of sweats, fever, muscle pain or raised temperature present.
X-ray (if carried out)	Clear	Diagnostic – shadowing can be seen. Not often carried out in the community.
Treatment	Antibiotics usually inappropriate	Antibiotic therapy necessary to reduce morbidity and mortality.

The recommended first-line antibiotic for CAP is amoxicillin 500-1000mg tds for 7-10 days (or erythromycin 500mg qds).

Referral to hospital

Admission to hospital is needed in 20-40% of patients with CAP.⁴

BTS recommend assessing the severity using the CRB-65 score for people diagnosed with pneumonia³. One point is awarded for each of the following features:

- **Confusion** – recent onset.
- **Respiratory rate** 30 breaths/min or greater.
- **Blood pressure** – systolic of 90 mmHg or less or a diastolic of 60 mmHg or less.
- **65 years** of age or older.

- For people with a **CRB-65 score of 3 or more**, arrange urgent admission to hospital as high risk of death
- For people with a **CRB-65 score of 1 or 2**, hospital referral and assessment should be considered, particularly with score 2 (increased risk of death)
- People with a **CRB-65 score of 0**, do not normally require hospitalisation for clinical reasons (low risk of death)

References:

1. www.Cks.library.nhs.uk (Community acquired pneumonia) December 2007.
2. British Thoracic Society Guidelines of the Management of Community acquired Pneumonia in adults. Thorax 2001; 56, suppl4: 1-64
3. British Thoracic Society Guidelines of the Management of Community acquired Pneumonia in adults. 2004 update www.brit-thoracic.org.uk
4. Pneumonia: update on diagnosis and management. BMJ 2006; 332: 1077-9

Probiotics for irritable bowel syndrome?

A variety of probiotics products are commercially available, including yoghurts, sachets and capsules. They are classed as food supplements rather than licensed medicinal products. They contain one or more bacteria, typically *Bifidobacterium*, *Lactobacillus* and *Streptococcus thermophilus*. Despite growing interest in, and availability of, probiotics products, data on their effectiveness in IBS are limited. Current and draft guidelines for the management of IBS do not give clear guidance for prescribers considering probiotics.

The following points should be considered:

- there is no conclusive scientific evidence for the effectiveness of probiotics for IBS;
- not all probiotics are alike; different bacteria and strains may have different effects;
- most probiotics products have not been tested for the accuracy of their claimed bacterial content, shelf stability or intestinal survival.

There are conflicting data for studies using the same bacteria. A recent review article¹ describes an 8-week study of VSL#3 in patients with IBS that found no difference in primary endpoints but a statistically significant improvement in abdominal bloating, a secondary endpoint. A further study focusing on IBS patients with abdominal bloating showed no effect on this symptom.

For the management of IBS, it would be prudent to use other agents that have more robust evidence and probiotics are not locally recommended.

1. Gastroenterology 2007; 132(2): 813-816

Acute sinusitis – to treat or not to treat?

Despite the clinical uncertainty as to a bacterial cause in everyday practice and despite RCTs showing lack of benefit of antibiotics for clinically diagnosed acute sinusitis, antibiotic prescribing rates remain high. A new UK study adds to the evidence base that antibiotics are not effective as a treatment for acute sinusitis in the primary care setting¹.

Adult patients older than 15 years with uncomplicated acute illness (<28 days duration) who presented to a primary care practice with symptoms of sinusitis were recruited. Patients had to be positive for a minimum of 2 of the 4 Berg and Carenfelt criteria*. They were randomised to 1 of 4 treatment groups: antibiotic and nasal steroid; placebo antibiotic and nasal steroid; antibiotic and placebo nasal steroid; placebo antibiotic and placebo nasal steroid. The interventions were amoxicillin 500mg tds for 7 days and budesonide 200mcg in each nostril once per day for 10 days. The main outcome measure was proportion clinically cured at day 10 using patient symptom diaries and the duration and severity of symptoms.

The proportions of patients with symptoms lasting 10 or more days were 29 of 100 (29%) for amoxicillin vs 36 of 107 (33.6%) for no amoxicillin (AOR, 0.99; 95% CI, 0.57 to 1.73). The proportions of patients with symptoms lasting 10 or more days were 32 of 102 (31.4%) for topical budesonide vs 33 of 105 (31.4%) for no budesonide (AOR, 0.93; 95% CI, 0.54 to 1.62). Cox regression confirmed the lack of a significant effect of amoxicillin (hazard ratio for resolution, 1.08 [95% CI, 0.79 to 1.48]; p=0.63) or budesonide (hazard ratio, 1.05 [95% CI, 0.77 to 1.44]; p=0.75). No noticeable differences were observed in time to cure for any of the groups with 40% of patients cured by 1 week.

The authors conclude that neither an antibiotic nor a topical steroid alone or in combination was effective as a treatment for acute sinusitis in the primary care setting. They comment that the trial is the largest non-pharmaceutically funded double-blind, placebo-controlled RCT assessing the effectiveness of amoxicillin and the only adequately powered trial of budesonide in this patient group.

A recent review has suggested that most cases of acute rhinosinusitis resolve with symptomatic treatment and analgesics, which should remain the main stay of treatment². The accompanying editorial to this trial comments that some patients with sinusitis are more ill than others with fever, malaise, and deteriorated general condition. These patients are in need of antibiotics, although they are relatively uncommon in general practice³.

1. JAMA 2007; 298:2487-94
2. BMJ 2007; 334:358-61
3. JAMA 2007; 298:2543-4

* **Berg and Carenfelt clinical criteria for acute bacterial sinusitis**

- Purulent nasal discharge with unilateral predominance
- Local pain with unilateral predominance
- Purulent nasal discharge bilaterally
- Pus on inspection inside the nose

Outcome data for rosuvastatin?

To date trials have shown that rosuvastatin has efficacy in lowering LDL-cholesterol levels but no trials have addressed whether it is effective at improving patient-orientated outcomes (POOs). A randomised controlled trial with POOs has recently been published. CORONA investigated the beneficial effects of rosuvastatin in patients with chronic, symptomatic, systolic, ischaemic heart failure¹.

A total of 5011 patients at least 60 years of age with NYHA class II, III, or IV ischaemic, systolic heart failure were randomised to receive 10mg of rosuvastatin or placebo per day. Median follow-up was 33 months. The primary outcome was a composite of death from CV causes, nonfatal MI, or nonfatal stroke.

As compared with the placebo group, patients in the rosuvastatin group had decreased levels of LDL-C ($p<0.001$) and of high-sensitivity C-reactive protein ($p<0.001$). However, there was no difference in the primary outcome (HR 0.92; CI 0.83 to 1.02; $p=0.12$). There was no difference in the death rates in the two groups (HR 0.95; CI 0.86 to 1.05; $p=0.31$).

Rosuvastatin is classified as DARK BROWN in Derbyshire.

1. N Engl J Med 2007; 357:2248-61

Adverse effects of ACEI plus ARB in heart failure

There is enthusiasm in some quarters for the combination of ACEI and ARB in patients with symptomatic left ventricular dysfunction. A systematic review has been conducted to quantify the magnitude of risk of adverse effects associated with this combination¹.

These important adverse events were increased by combination ACEI plus ARB compared with treatment that included an ACEI alone in chronic heart failure.

Medication discontinuations because of adverse effects

RR 1.38 (CI 1.22 to 1.55); number needed to harm = 25.

Symptomatic hypotension

RR 1.50 (1.09 to 2.07); NNH = 111.

Worsening renal function

RR 2.17 (1.59 to 2.97); NNH = 56.

Hyperkalaemia

RR 4.87 (2.39 to 9.94); NNH = 36.

As the authors comment, worsening renal function in patients with chronic HF is associated with a poor prognosis. In addition, these types of adverse effects can negatively affect patients' quality of life and reduce overall benefit as a result of increased risk of medication nonadherence.

1. Arch. Intern Med 2007; 167:1930-6

Cardiovascular safety of glitazones in older people

A large population-based study from Canada increases concerns over the cardiovascular risk of glitazones, and in particular rosiglitazone, in older people with diabetes, regardless of their baseline cardiovascular (CV) risk¹. This was a retrospective, nested case-control study of 159,026 people with diabetes aged 66 years or older with a median follow-up of 3.8 years.

The authors claim that this is the first study to evaluate glitazone-related outcomes in an entire population of older people with diabetes. It demonstrates an increase risk of HF, MI and all-cause mortality with the use of glitazones (mainly rosiglitazone) compared with non-glitazone oral hypoglycaemic therapy. They estimate the numbers needed to harm over four years to be as low as 34 for HF, 26 for MI, and 22 for death in the population studied.

Older people form a large proportion of the population of patients with diabetes, and are often underrepresented in many RCTs. This study provides an insight into the effects of glitazones in "real-life" clinical practice where treatment of older people with diabetes is often complicated by comorbidities that put them at higher risk. The data provides support for the view that there is a greater risk of cardiovascular events with rosiglitazone than with the older more established oral hypoglycaemic agents (i.e. metformin and sulphonylureas).

The NPC make the following recommendations in their review of this study²:

"Our view is that the time has come for prescribers to begin proactively reviewing patients taking rosiglitazone and discussing these data and alternative strategies. It seems less clear whether there are similar issues with pioglitazone.

Clinicians and patients should bear in mind that controlling cardiovascular risk in type 2 diabetes by smoking cessation, controlling blood pressure, and improving the TC:HDL ratio with a statin reduces macrovascular events, whereas intensively controlling blood glucose – at least with insulin and sulphonylureas – does not (see the Type 2 diabetes floor on NPCi)."

You can access NPCi at www.npci.org.uk

1. JAMA 2007; 298:2634-43

2. www.npci.org.uk/blog/?p=48 (accessed 21/12/07)

Thyroid function abnormalities during amiodarone therapy

Data from a sub-analysis of the SAFE-Trial, a prospective RCT of amiodarone, sotalol, and placebo for persistent atrial fibrillation, were evaluated to determine the extent of amiodarone-induced thyroid dysfunction in a large male cohort¹. In this sub-study (n=612), sotalol and placebo groups were combined into a control group and serial thyroid function tests were carried out over 1 to 4.5 years. The following results were reported:

- subclinical hypothyroidism (thyroid-stimulating hormone [TSH] 4.5 to 10 mU/L) was seen in 25.8% of amiodarone-treated patients and 6.6% of controls (p <0.0001); NNH = 5
- overt hypothyroidism (TSH >10 mU/L) was seen in 5.0% of amiodarone-treated patients, and 0.3% of controls (p <0.001); NNH = 21
- by 6 months, 93.8% of patients who developed TSH elevations > 10 mU/L on amiodarone had been detected
- there was a non-statistically significant trend toward a greater proportion of hyperthyroidism, defined as TSH < 0.35 mU/L in the amiodarone group vs. control (5.3% vs 2.4%, p = 0.07)
- hypothyroidism developed in 30.8% of older males treated with amiodarone and in 6.9% of the controls, and presented at an early stage of therapy; NNH = 4.

During amiodarone therapy, all patients should be carefully monitored for both hypothyroidism and hyperthyroidism. Six-monthly checks of thyroid function are recommended. A recent audit in 8 Derbyshire GP practices found that 35% of patients on amiodarone did not have a TFT result recorded in the last 6 months and 16% had no TFT result recorded in the last year. An amiodarone monitoring protocol has recently been developed for use in Derbyshire. Contact myself or your locality prescribing adviser for a copy.

1. Am J Med 2007; 120:880-5

Update on HPV vaccine

The planned programme is that HPV vaccine will be introduced for girls aged 12-13 years (school year 8) from autumn 2008, and thereafter. Three doses of the HPV vaccine over a six-month period are needed for protection.

A catch-up programme will start in autumn 2009 and will run for two years as follows:

- girls aged 16 to 18 years (school years 12 and 13) will be offered the vaccine from autumn 2009,
- girls aged 15 to 17 years (school years 11 and 12) will be offered the vaccine from autumn 2010.

By the end of the catch-up campaign all girls under 18 years of age will have been offered the HPV vaccine.

The JVICI did not make a recommendation about which of the two licensed HPV vaccines (Gardasil and Cervarix) should be offered. It is highly likely that the vaccine itself will be purchased centrally, though this remains to be confirmed. The PCTs are currently determining the distribution process, which will be complex and involves other stakeholders.

Until the planned programme starts, the PCTs' position regarding prescribing the vaccine remains unchanged.

The Primary Care Trusts do not recommend the vaccine be prescribed in primary care on the NHS, as this would represent inappropriate use of resources in light of the commencement of the vaccination programme in September. In addition, it is recommended not to provide the vaccine on a private prescription.

Further information can be obtained from Sue Cohen, Consultant in Public Health, on 01246 514350 for Derbyshire County PCT or Laraine Tuplin, Assistant Director Medicines Management, on 01332 203102 Ext 6335 for Derby City PCT.