

NEWSLETTER

Supporting the Derbyshire Health Community

Volume 8: Issue 5

August 2009

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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 lies with a hospital consultant or a specialist. AMBER drugs are those that are initiated within a hospital/specialist setting but are suitable for shared care with a GP under a shared care agreement. GREEN drugs are regarded as suitable for primary care prescribing. BROWN drugs are those that JAPC does not recommend for use, except in exceptional circumstances, due to lack of data on safety, effectiveness, and/or cost-effectiveness.

The most recent updates are in the table below; the full list is available at

<http://www.derbyshirecountypct.nhs.uk/guidelines/default.asp>

The guidelines, formulary chapters, newsletters, etc can now be found via this link.

Drug	Date considered	Decision
n-Acetylcysteine tabs	August 2009	AMBER
Degarelix injection	August 2009	BROWN
Fluticasone furoate nasal spray (Avamys)	August 2009	GREEN (after consultant initiation)
Liraglutide injection	August 2009	RED
Histrelin implant	August 2009	RED
Olapatadine eye drops	August 2009	GREEN (3 rd line use only)
Ondansetron tabs	July 2009	BROWN (moved from RED)
Optive eye drops	July 2009	GREEN

Antivirals for flu

Obviously there is a bit of extra interest in managing flu at the moment and we have been asked 'what is the evidence for the use of antivirals?' There are two Cochrane reviews on the neuraminidase inhibitors (Nis); one for adults¹ and one for children².

Neuraminidase inhibitors for preventing and treating influenza in healthy adults

Main results

We identified four prophylaxis, 13 treatment and four post-exposure prophylaxis (PEP) trials. In prophylaxis compared to placebo, NIs have no effect against influenza-like illnesses (ILI) (relative risk (RR) 1.28, 95% confidence interval (CI) 0.45 to 3.66 for oral oseltamivir 75 mg daily; RR 1.51, 95% CI 0.77 to 2.95 for inhaled zanamivir 10 mg daily). The efficacy of oral oseltamivir 75 mg daily against symptomatic influenza is 61% (RR 0.39, 95% CI 0.18 to 0.85), or 73% (RR 0.27, 95% CI 0.11 to 0.67) at 150 mg daily. Inhaled zanamivir 10 mg daily is 62% efficacious (RR 0.38, 95% CI 0.17 to 0.85). Neither NI has a significant effect on asymptomatic influenza.

Oseltamivir induces nausea (odds ratio (OR) 1.79, 95% CI 1.10 to 2.93). Oseltamivir for PEP has an efficacy of 58.5% (15.6% to 79.6) for households and of 68% (34.9 to 84.2%) to 89% in contacts of index cases. Zanamivir

has similar performance. The hazard ratios for time to alleviation of influenza symptoms were in favour of the treated group 1.33 (1.29 to 1.37) for zanamivir and 1.30 (1.13 to 1.50) for oseltamivir. Viral nasal titres were significantly diminished by both NIs. Oseltamivir 150 mg daily prevented lower respiratory tract complications (OR 0.32, 95% CI 0.18 to 0.57). We could find no comparative data on the effects of oseltamivir on avian influenza.

Authors' conclusions

Because of their low effectiveness, NIs should not be used in routine seasonal influenza control. In a serious epidemic or pandemic, NIs should be used with other public health measures. We are unsure of the generalisability of our conclusions from seasonal to pandemic or avian influenza

Plain language summary

Influenza is an acute infection of the airways and the whole body, caused by a virus. Symptoms include fever, headache and cough. Serious complications such as pneumonia can also occur. This review of trials found that neuraminidase inhibitors (NIs) such as zanamivir and oseltamivir are effective in preventing ("prophylaxis") and treating ("treatment") the symptoms and complications of influenza but do not prevent infection or interrupt avoidance of viruses from the nose. Oseltamivir causes nausea, vomiting and retching while zanamivir causes diarrhoea. There is no evidence that NIs may be effective against bird flu. Because of their performance, NIs should not be used on their own, but alongside barrier (masks, gloves), personal hygiene and quarantine measures.

No NNTs are provided in the review. Interesting statement in the discussion – 'prophylactic use of NIs in a serious epidemic or a pandemic may enhance vulnerability to infection by preventing seroconversion and facilitating the selection of NI-resistant mutant viruses.'

Neuraminidase inhibitors for preventing and treating influenza in children

Main results

Three trials involving 1500 children with a clinical case definition of influenza were included, of whom 977 had laboratory-confirmed influenza. Overall, trial quality was good. Oseltamivir reduced the median duration of illness by 26% (36 hours) in healthy children with laboratory-confirmed influenza (P value less than 0.0001). The reduction was only 7.7% (10 hours) in 'at risk' (asthmatic) children, and this did not reach statistical significance (P value = 0.54). Zanamivir reduced the median duration of illness by 24% (1.25 days) in healthy children with laboratory-confirmed influenza (P value less than 0.001). No data in 'at risk' children were available. Only oseltamivir produced a significant reduction in the complications of influenza (particularly otitis media), although there was a trend to benefit for zanamivir. We identified one randomised, controlled trial of oseltamivir for the prevention of influenza transmission in households, reporting data from 222 paediatric contacts. Where index cases had laboratory-confirmed influenza, a protective efficacy of 55% was observed, but this did not reach statistical significance (P value = 0.089). The adverse events profile of zanamivir was no worse than placebo, but vomiting was more common in children treated with oseltamivir.

Authors' conclusions

Neuraminidase inhibitors are effective in shortening illness duration in healthy children with influenza, but efficacy in 'at risk' children remains to be proven. Oseltamivir is also effective in reducing the incidence of secondary complications, and may be effective for influenza prophylaxis.

Plain language summary

Influenza (true "flu") is an infection of the airways caused by a virus. Infection may be treated with neuraminidase inhibitors (zanamivir and oseltamivir), one group of anti-influenza drugs. This review found that both drugs shortened the duration of illness in healthy children by about one day. Oseltamivir also prevented complications of influenza, in particular, ear infections. More research is needed to determine if the drugs are also helpful for: 'at risk' children (who have a pre-existing medical condition); and preventing (rather than treating) influenza in children. Neither drug caused serious side effects.

No NNTs are provided except for otitis media – NNT of 11 for children aged 1-12 years to prevent one case, assuming treatment of all children. For those aged 1-5, NNT of 5. These are of course best case scenarios.

1. *Cochrane Database of Systematic Reviews*, Issue 3, 2009 DOI: 10.1002/14651858.CD001265.pub2
2. *Cochrane Database of Systematic Reviews*, Issue 3, 2009 DOI: 10.1002/14651858.CD002744.pub2

Stopping long-term amiodarone

The following advice was recently ratified and is now an appendix to the [amiodarone monitoring protocol](#).

Amiodarone is a very effective antiarrhythmic drug, often used in the treatment of paroxysmal atrial fibrillation (PAF) and ventricular tachycardia (VT). Unlike most other antiarrhythmics, it is safe in heart failure. Its use is limited by side-effects, some of them life-threatening. The risk of these side-effects increases with time and with dose. It seems sensible therefore to ask from time to time whether the drug is still indicated and whether the dose can be reduced. The following is a simple guide to establishing whether amiodarone should be continued at its present dose, or whether treatment can be reduced or withdrawn completely.

Step 1: Establish the original indication for amiodarone therapy

1. paroxysmal atrial fibrillation (PAF)
2. permanent AF
3. ventricular tachycardia (VT)
4. Wolff-Parkinson-White syndrome (WPW)
5. palpitations of uncertain cause

Step 2: Review diagnosis & need for amiodarone in light of current status

1. The natural history of PAF is for it to become chronic at some stage (25% in 5 years). This may happen 'silently'. AF can be considered permanent when the patient has been shown to be in AF on two occasions and no longer reports symptoms of cardiac rhythm change. When a patient develops permanent AF the amiodarone should be stopped and heart rate controlled with beta blockers, calcium channel blockers or digoxin. The usual amiodarone dose in PAF is 200 mg od. If a patient has been very stable for a year or more this can be reduced to 100 mg.
2. Very occasionally it is necessary to use amiodarone for rate control in permanent AF. As other rate control options (eg AV nodal ablation plus pacemaker insertion) could be considered, all patients on amiodarone for rate control should initially be under the care of a cardiologist. Once a patient has been stable for two years it is worth considering reducing or stopping amiodarone without necessarily referring back to hospital. The long terminal half-life of amiodarone means that it will take months before its effect on AV node conduction has gone completely.
3. Patients with symptomatic VT should remain on amiodarone in the long term unless they develop significant side-effects. Patients with internal cardiac defibrillators (ICDs) are often also on amiodarone to reduce the frequency of shocks. Some patients are started on amiodarone for VT at the time of an acute illness. Any patient who has been completely well for two years with no suggestion of recurrent VT should be referred to a cardiologist for review of the long-term need for amiodarone.
4. Amiodarone is rarely used for WPW, unless an electrophysiologist has been unsuccessful in ablating an accessory pathway. Some WPW patients were started on amiodarone before the modern era of percutaneous treatments. Some are happy to stay on amiodarone but they should be given the opportunity to discuss definitive treatment with an electrophysiologist.
5. Patients should not be started on amiodarone unless there is a clearly defined electrophysiological diagnosis. If a patient was started on amiodarone because of suspicion of VT but has been stable for two years they should be reviewed by a cardiologist. If the indication was just palpitations then the amiodarone should be stopped.

Step 3: stopping amiodarone

- Amiodarone can be stopped abruptly
- Amiodarone lingers long after the drug is stopped. Plasma concentration falls by 50% in the first two weeks but it may then take a further 6 months before it is eliminated completely
- Ventricular rate control and AF: if resting heart rate is < 75 review in 2 weeks to consider increasing dose of other rate slowing drugs (NB the plasma level of digoxin will decrease upon withdrawal of amiodarone). If resting heart rate is >75 add in or increase beta blocker, digoxin, rate-limiting calcium channel blocker (e.g. start atenolol 25 mg or increase dose by same amount up to 100 mg). A further review of heart rate at 3 months after stopping amiodarone is sensible.
- Liver and thyroid function tests: these should be repeated until 12 months after stopping the amiodarone as very occasionally thyroid dysfunction has been documented up to a year after stopping it.
- Warfarin: the INR will decrease upon stopping amiodarone. In most cases it is sufficient to repeat the INR one week after stopping in the expectation that a dose increase will be necessary

Update on safety of insulin glargine

The European Medicines Agency (EMA) is looking into four recently published registry studies investigating a possible relationship between insulin analogues, in particular insulin glargine, and the risk of cancer. The studies were published on the Diabetologia website on 26 June 2009.

Insulin glargine is a long-acting insulin analogue, authorised in the European Union as Lantus and Optisulin, for the treatment of adults, adolescents and children aged six years or above with diabetes, when treatment with insulin is required.

The results of the four studies were found to be inconsistent. In two studies (Scottish Diabetes Research Network Epidemiology Group and Jonasson et al) an association between breast cancer was found in a group of patients taking insulin glargine as monotherapy, but not in another group of patients using insulin glargine together with other types of insulin. For other cancers, no association was found. In these two studies dose-dependency was not evaluated. The third study (Hemkens et al) reported a dose-dependent association between use of insulin glargine and malignancies. However, no information is available on the types of cancer found in this study. In the fourth study (Currie et al), no association between cancer (either breast, colorectal, pancreatic or prostate cancer) and the use of insulin glargine, or any other insulin, was found.

On the basis of the currently available data, a relationship between insulin glargine and cancer cannot be confirmed nor excluded. However, the concerns raised by the four studies require further in-depth evaluation.

The Agency's Committee for Medicinal Products for Human use (CHMP) will perform a detailed assessment of the studies' results and any other relevant information. This review will also address issues, such as dose-response effects, the implications of the relatively short duration of the studies and influence of other factors on the risk of breast cancer and other cancers (e.g. age, body mass index (BMI), menopausal status, parity, socioeconomic status).

This is the advice from the NPC¹

"The EMA has advised no change in practice is required at present, and patients being treated with insulin glargine can continue their treatment as normal (in accordance with NICE guidance on type 1 and type 2 diabetes). However, these papers could constitute an important signal about the long-term safety of insulin glargine, and until the CHMP review is complete some patients and prescribers may wish to review their use of it in the light of their own particular circumstances.

The effect of NICE guidance ought to be that the insulin analogues are not used routinely. However, the prescribing data for England shows that the uptake of insulin glargine and insulin detemir is now extensive. Based on the figures for the quarter to December 2008, there are about 1,200,000 items of insulin glargine prescribed each year, and 400,000 items of insulin detemir. This equates to approximately 40% of all intermediate/long acting insulin items.

Whether or not a link between an increased risk of cancer and insulin glargine is established, given that the costs per QALY are so large for these analogue insulins, it may be prudent for prescribers and prescribing managers to now review the use of these drugs to see if their current use is indeed in line with NICE guidance."

1. www.npci.org.uk/blog/?p=374

The RECORD Study

Adverse effects that have been associated with both rosiglitazone and pioglitazone include weight gain, increased incidence of fractures, fluid retention and a two-fold increased risk of heart failure. Most importantly, meta-analyses have reported a 30-40% increase in the risk of MI in patients treated with rosiglitazone. These findings have raised considerable uncertainty about the effects of glitazones on cardiovascular disease¹.

The RECORD study was recently published in the Lancet². This trial assessed CV outcomes after addition of rosiglitazone to either metformin or sulfonylurea compared with the combination of the two over 5-7 years of follow-up. RECORD was an open-label trial and was a non-inferiority (rather than a superiority) study. (For an explanation of non-inferiority studies see DTB July 2008).

The primary endpoint was CV hospitalisation or CV death, with a hazard ratio non-inferiority margin of 1.20 (upper 95% CI 1.20 or less). In other words, the authors decided that dual therapy including rosiglitazone would be judged no more harmful than standard dual therapy of metformin plus a sulfonylurea, if there was less than a 2.5% probability that it did not increase the risk of the composite outcome by 20% or more.

After a mean 5.5 year follow up the HR for the primary outcome was 0.99 (95% CI 0.85 to 1.16). There was a non-statistically significant increased risk of MI in the rosiglitazone group (HR 1.14 [0.80 to 1.63]). The HR for heart failure causing admission to hospital or death was 2.10 (1.35 to 3.27, p=0.001). The risk of participant reported bone fractures was greater in the rosiglitazone group: RR 1.57 (1.26 to 1.97, p<0.0001).

As well as being a non-inferiority study, there are other study limitations. It was an open-label design, CV event rates were lower than anticipated, and rosiglitazone was associated with higher LDL-C levels leading to an increased use of statins in this arm, which might have reduced the incidence of CV events. As the editorial¹ says “although the RECORD study has confirmed known risks associated with rosiglitazone (including increased rates of heart failure, fractures, and hyperlipidaemia), uncertainty remains regarding the effect of rosiglitazone on cardiovascular events”.

The NPC³ comments:

“The authors of this non-inferiority study claim non-inferiority of dual therapy with rosiglitazone plus metformin or a sulfonylurea compared to dual therapy with metformin plus a sulfonylurea with regard to major CV outcomes. However, questions over the analysis limit the degree of confidence which can be placed in this conclusion. The study confirms that therapy including rosiglitazone substantially increases the risk of heart failure as well as increasing the risk of fractures, and overall provides additional support for a strategy of reviewing patients taking rosiglitazone and considering their hypoglycaemic medication in the light of recently updated NICE guidance and MHRA advice.”

If a glitazone is clinically indicated, the JAPC choice is pioglitazone. See the new guideline on [glucose control in type 2 diabetes](#).

1. Lancet 2009; 373:2088-90
2. Lancet 2009; 373:2125-35
3. www.npci.org.uk/blog/?p=360

Triptans and SSRIs – is there an interaction?

Triptans and selective serotonin re-uptake inhibitors (SSRIs) are in common use in individuals suffering from migraine and depression. Studies have demonstrated high rates of depression in individuals suffering from migraine, and vice versa. Therefore, there is significant potential to co-prescribe these agents. Both triptans and SSRIs have serotonergic activity; triptans are serotonin agonists and SSRIs inhibit the active re-uptake of serotonin into nerve terminals

When the first triptan, sumatriptan, was launched in the UK in 1992, co-prescription with SSRIs was contraindicated because of the theoretical increased risk of serotonin syndrome. Subsequent experience resulted in the original contraindication being replaced by a warning of a possible interaction. A further six triptans are now available in the UK, as well as newer SSRIs and also SNRIs (serotonin and noradrenaline re-uptake inhibitors). The question of an interaction existing between triptans and SSRIs or SNRIs, and the possible clinical significance of such an interaction, has been considered in a [UKMi Q&A](#)¹.

This is the summary:

- ◆ Triptans and selective serotonin/noradrenaline reuptake inhibitors (SSRIs/SNRIs) are in common use in individuals suffering from migraine and depression. It has been postulated that concurrent use may result in serotonin syndrome, via a pharmacodynamic (additive effects on the serotonin system) or pharmacokinetic (inhibition of triptan metabolism by SSRIs/SNRIs) interaction.
- ◆ The weight of evidence suggests that use of a triptan and an SSRI together is normally uneventful (there are fewer data relating to SNRIs). However, in July 2006, the US Food and Drug Administration Agency (FDA) issued an Alert on the basis of a small number of reports of serotonin syndrome noted during concurrent use. The agency asked manufacturers to update their prescribing information to include a warning of a possible interaction. No similar statement has been issued by the UK regulatory authority (MHRA). Despite this, all UK

Summary of Product Characteristics (SPCs) for triptans have been updated in line with US prescribing information.

- ◆ A conservative approach is to avoid the combination of a triptan and an SSRI/SNRI, but this may deny patients access to effective medication. A pragmatic approach is to use the combination with caution and monitor for signs and symptoms of serotonin syndrome (e.g. restlessness, sweating, tremor, shivering) particularly during treatment initiation, with dose increases, or with the addition of another serotonergic medicine.
- ◆ In theory, on pharmacokinetic grounds triptans with modest lipid solubility and a short half-life may be the safer choice, e.g. sumatriptan, rizatriptan or zolmitriptan. It would seem sensible to avoid frovatriptan as a first-line triptan in a patient on an SSRI/SNRI because of its long half-life. On the basis of the strength of warnings included in individual SPCs, prescribers may prefer not to use:
 - ◆ frovatriptan or zolmitriptan with fluvoxamine
 - ◆ sertraline in combination with any triptan.
- ◆ The herbal medicine St John's wort (*Hypericum perforatum*) used for treatment of depression may increase serotonin levels and the MHRA has advised that it should not be taken concurrently with a triptan.

1. UKMi Q&A 48.5

Drug Safety Update

This can be found at www.mhra.gov.uk/publications/safetyguidance/drugsafetyupdate/index.htm

These are some key points from the July issue.

Clopidogrel and proton pump inhibitors: interaction

Concomitant use of a PPI with clopidogrel should be avoided unless considered essential.

Advice for healthcare professionals:

- The need for PPI therapy in patients who are also taking clopidogrel should be reviewed at their next appointment: avoid concomitant use of these medicines unless considered essential.
- Prescribe PPIs in line with their licensed indications where possible.
- Check whether patients who are taking clopidogrel are buying over-the-counter omeprazole and consider whether another gastrointestinal therapy would be more suitable.

Use of long-acting beta-agonists in chronic obstructive pulmonary disease

The overall benefits of long-acting β -agonists (LABAs), both as monotherapy and in combination with inhaled corticosteroids (ICS), in the treatment of chronic obstructive pulmonary disease (COPD) continue to outweigh any risks. However, healthcare professionals are reminded that ICS should not be used alone in COPD. A key issue remains the increased risk of pneumonia associated with the use of ICS in COPD.

Advice for healthcare professionals

- The overall balance of benefits and risks for LABAs in the treatment of COPD remains positive when used in line with current GOLD and NICE guidelines
- In all trials combination therapy was better than monotherapy. However the benefit is limited and ICS should be introduced only when COPD progresses to severe disease, in line with current guidelines
- ICS should not be used alone in COPD
- A key issue is the increased risk of pneumonia with ICS treatment in COPD. This risk is not apparent with LABAs alone

Revised British Asthma Guideline

SIGN and BTS have issued a revised [British Guideline on the Management of Asthma](#). The 2009 update includes revisions to the sections on pharmacological management, acute asthma and the management of asthma in pregnancy.

The revised SIGN/BTS British asthma guideline is an essential read for clinicians involved in the care of patients with asthma, particularly the updated sections on acute asthma and asthma in pregnant women. A [quick reference guide](#) is also available.

What has been updated?

The SIGN/BTS asthma guideline was previously updated and re-issued in May 2008. In this 2009 update, the familiar stepwise approach remains unchanged from previous versions. The only sections that have been revised are:

- Section 4 – pharmacological management
- Section 6 – management of acute asthma
- Section 7.3 – asthma in pregnancy

A full literature search was conducted on inhaler devices, but no new evidence was identified to alter current recommendations.

What are the new key messages?

The key messages from the new guidance include:

- Oxygen levels in patients with acute asthma should be maintained at SpO₂ 94-98%
- Oxygen saturation should be measured by pulse oximeters in adults and children. Pulse oximeters should be available for all health professionals assessing acute asthma in both primary and secondary care.
- The importance of action plans in controlling asthma and reducing future hospitalisation is reinforced.
- Advice on the safe use of treatment during pregnancy is reinforced.

Furthermore, the doses of inhaled corticosteroids (ICSs) were previously referenced against beclometasone (BDP) given via CFC-metered dose inhaler. This preparation has now been phased out, and the reference ICS is now BDP-HFA (CFC-free) equivalent. The updated SIGN/BTS guideline now contains a helpful table showing the equivalent doses of ICSs relative to BDP, and current licensed age indications.

Equivalent doses of inhaled steroids relative to BDP and current licensed age indications

Those dosage equivalents are approximate and will depend on other factors such as inhaler technique.

Steroid	Equivalent dose	UK licence covers		
		>12 Years	5 – 12 Years	<5 years
Beclometasone dipropionate CFC	400 mcg	No longer available		
Beclometasone				
Clenil modulite	400 mcg	✓	✓	✓
Clickhaler	400 mcg	✓	Over age 6	×
Aerobec Autohaler	400 mcg	✓	×	×
Asmabec Clickhaler	400 mcg	✓	Over age 6	×
Dry powder (Becodisks)	400 mcg	✓	✓	✓
Easyhaler	400 mcg	✓	×	×
Pulvinal	400 mcg	✓	Over age 6	×
Filair	400 mcg	✓	✓	✓
Qvar	200 to 300 mcg	✓	×	×
Fostair	200 mcg	Over age 18	×	×
Budesonide				
Turbohaler	400 mcg	✓	✓	×
Metered dose inhaler	400 mcg	✓	✓	Over age 2
Easyhaler	400 mcg	✓	Over age 6	×
Novolizer	400 mcg	✓	Over age 6	×
Symbicort	400 mcg	✓	Over age 6	×
Symbicort (regular and as required dosing)	400 mcg	Over age 18	×	×
Fluticasone				
Metered dose inhaler (HFA)	200mcg	✓	✓	Over age 4
Accuhaler	200mcg	✓	✓	Over age 4
Seretide HFA	200mcg	✓	✓	Over age 4
Seretide (Accuhaler)	200mcg	✓	✓	Over age 4
Mometasone	200mcg	✓	×	×
Ciclesonide	200 to 300mcg	✓	×	×

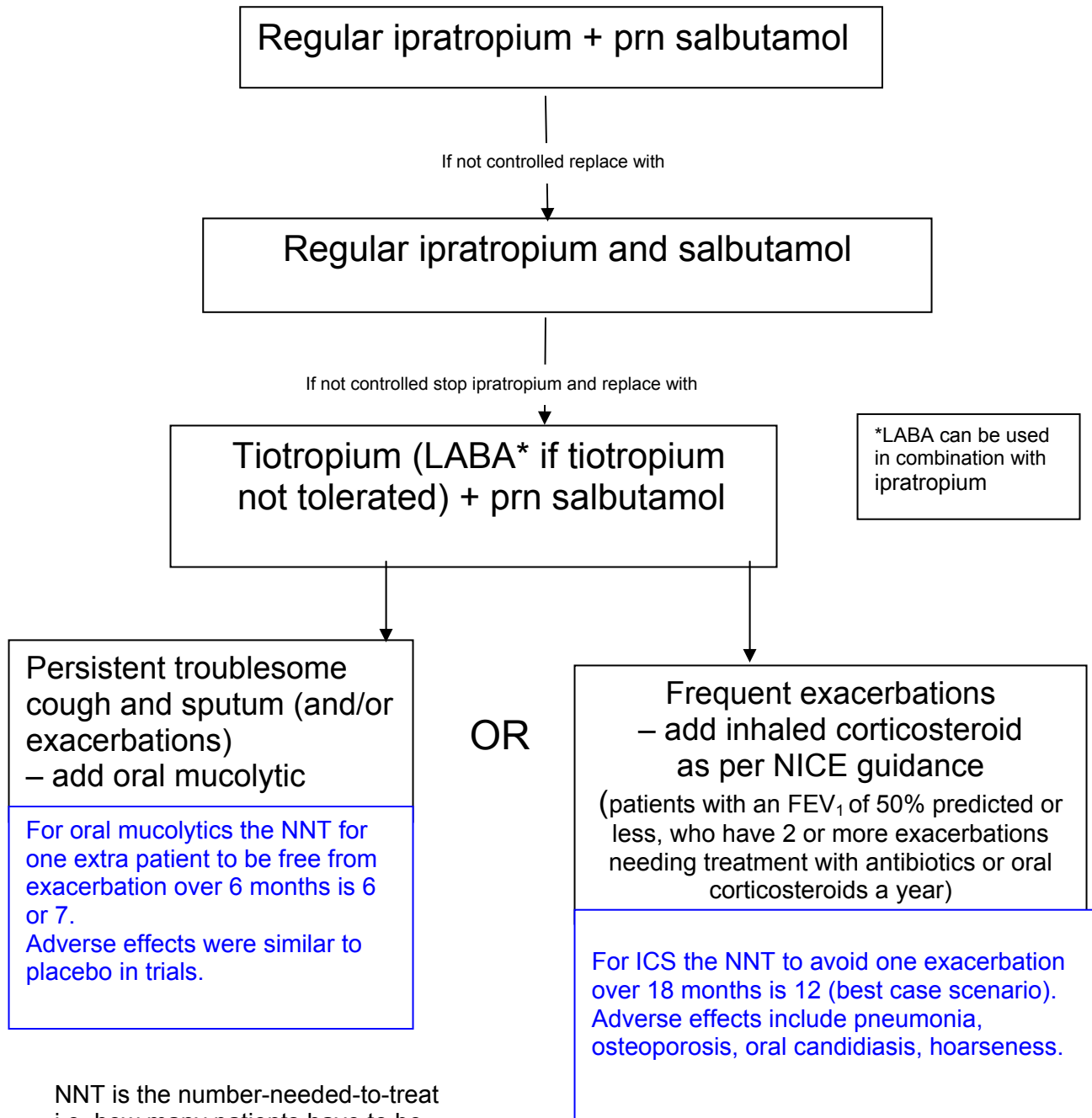
Ciclesonide is a new inhaled steroid. Evidence from clinical trials suggests that it has less systemic activity and fewer local oropharyngeal side effects than conventional inhaled steroids. The clinical benefit of this is not clear as the exact efficacy to safety ratio compared to other inhaled steroids has not been fully established.

Non-CFC beclometasone is available in more than one preparation, and the potency relative to CFC beclometasone is not consistent between these. *Remember to prescribe Clenil and Qvar by brand name.*

Algorithm for drug use in COPD

Airflow obstruction must be present before using bronchodilators.

When prn salbutamol is insufficient -



NNT is the number-needed-to-treat i.e. how many patients have to be treated for how long for one of them to benefit.

New initiatives for improving access to information for people with long term conditions

[Vanessa Vale – Long Term Conditions Commissioning Manager]

Information plays a crucial role in supporting people with long term conditions to take care of themselves and improve their quality of life. Up to now there has been no way to ensure that a person will have access to or receive the right information when they need it the most – at diagnosis and as their needs continue.

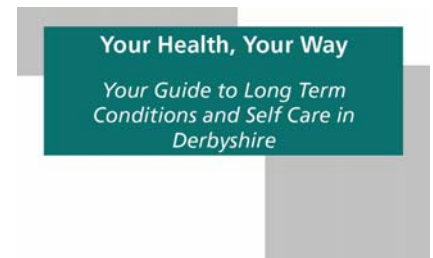
There are now two free ways in which patients, carers and health care professionals can access information about long term conditions and the services that are available to support them.



Information Prescriptions are a way of signposting people to important and reliable sources of information to help them manage their condition. This could be information about their condition such as medication and treatment or it could be practical information such as carers support or travel.

An information prescription is a directory that is full of suggestions of where people can get information from, locally and nationally, about long term conditions. It aims to ensure that people receive the information they need at a time that is suitable to them and in a format that they will understand.

The Your Health, Your Way Guide is a way of providing information about the support that is available from the local NHS services, social services or voluntary organisations for people living with an affected by long term conditions. This could be information such as stop smoking services, local support groups, education programmes or equipment that is available to help assist with independent living.



The Your Health Your Way Guide is full of information about the choices that are available locally, to help people maintain good health and take care of their condition.

Both of these initiatives are available from 1st August 2009. People can access them in any of the following ways:

- Internet: www.derbyshirecountypct.nhs.uk/long-term-conditions
- Local libraries: To find a local library Call Derbyshire 08456 058 058
- PALS: 0800 783 7279
- Health Care Professionals: People may also ask health care professionals about these initiatives. Information credit cards are soon to be distributed across Derbyshire so that these can be given directly to people should they want to get an Information Prescription or Your Health, Your Way Guide. This card will tell them the above ways in which people can request one.

Without information there is no choice. Information gives people the power and confidence to engage partners in health and social care!

If you have any questions or would like further information about these initiatives please contact:

Information Prescriptions – Vanessa Vale 0115 931 6157
Your Health, Your Way guide – Ciara Scarff 0115 931 615