Lincolnshire NHS

Prescribing and Clinical Effectiveness Bulletin

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This bulletin has been created specifically to convey details of decisions taken at the Prescribing and Clinical Effectiveness Forum (PACEF) to all stakeholders across the Lincolnshire Healthcare Community in both primary and secondary care. Steps will be taken to ensure the widest possible distribution across Lincolnshire PCT and within United Lincolnshire Hospitals Trust and Lincolnshire Partnership Trust. Both paper and electronic copies will be circulated initially with a view to evolving into complete electronic distribution as soon as we are confident that all key stakeholders can access E-mail. There are also plans to make all bulletins, guidelines, formularies, new product assessments, care pathways and other PACEF publications available through the LPCT website.

SUMMARY OF PACEF DECISIONS: FEBRUARY UPDATE

Drug	Indication	Traffic Light Status
Bicalutamide (Casodex)	**Licensed for the treatment of advanced prostatic cancer in combination with a gonadorelin analogue or surgical castration. Also licensed for the immediate treatment of locally advanced prostate cancer either alone or as adjuvant treatment. Also licensed for locally advanced, non-metastatic prostate cancer when surgical castration or other medical**	**AMBER** **Can be initiated in primary care subject to specialist request. No shared care guideline is required.**

	intervention is inappropriate or unacceptable	
Colesevelam (Cholestagel)	**Licensed as an adjunct to diet in patients with primary hypercholesterolemia who are not adequately controlled on a statin alone and as monotherapy as an adjunct to diet in patients with primary hypercholesterolemia in whom a statin is considered inappropriate or is not well tolerated.**	**RED-RED** **N.B. In exceptional circumstances maybe initiated by Lipid Clinic.**
Fostair (beclometasone 100mcg/ formoterol 6mcg) metered dose inhaler	**Licensed for the regular treatment of asthma where a combination ICS/LABA product is appropriate**	**GREEN** **N.B. Consider in new patients only.**
Infliximab (Remicade)	**Licensed for the treatment of moderate to severe plaque psoriasis in adults whose condition has failed to respond to, who have a contra-indication to, or who are intolerant of other systemic therapies including ciclosporin, methotrexate or PUVA.**	**RED**
Pemetrexed (Alimta)	**Licensed for use in combination with cisplatin for the treatment of chemotherapy naïve patients with unresectable malignant pleural mesothelioma**	**RED**
Varenicline (Champix)	**Licensed for smoking cessation in adults**	**GREEN** **N.B. Can be considered as a potential first line alternative to NRT subject to appropriate behavioural support**

RED-RED: This signifies that a product is **not recommended** for prescribing in **both** primary and secondary care. All new products are classified as RED-RED pending assessment by PACEF.
RED: This signifies that a product has been approved for use within ULHT and/or LPT **only** and has **no role in primary care**.
AMBER: This signifies that a drug has been approved for use in primary care **subject to specialist initiation; a shared care guideline (SCG) may also be required**. The main purpose of the SCG will be to clearly define both specialist and GP responsibilities. Not all AMBER drugs that require SCGs are currently covered by formal documents; in the coming months PACEF will be working to rectify this.
GREEN: This signifies a product that is **approved for initiation in either primary or secondary care**. Specialist initiation and shared care guidelines are not considered necessary.

NEW DRUG ASSESSMENTS

COLESEVELAM (CHOLESTAGEL)

Colesevelam (Cholestagel) is a new bile acid sequestrant (BAS) or anion-exchange resin. It is formulated as a 625mg film-coated tablet whereas the other BAS's currently available in the UK, cholestyramine and colestipol, are only available as powders and granules. Colesevelam is a non-absorbed polymer that binds to bile acids in the intestine and impedes their reabsorption. This leads to a depletion of bile acids in the body and the activation of the hepatic enzyme cholesterol 7-α-hydroxylase as a compensatory mechanism which converts cholesterol into bile acids. The resulting conversion of cholesterol to bile acids results in a fall in serum Low Density Lipoprotein–Cholesterol (LDL-C) levels.

Colesevelam (used in combination with a statin) is licensed as an adjunct to diet in patients with primary hypercholesterolemia who are not adequately controlled on a statin alone. It is also licensed as monotherapy as an adjunct to diet for the reduction of elevated LDL-C in patients with isolated primary hypercholesterolemia in whom a statin is considered inappropriate or is not well tolerated.

The majority of published clinical trials were short term (usually four to six weeks duration) and recruited only small patient numbers. None of the published trials provided comparative data with other BASs or measured outcomes other than effects on LDL-C and Total Cholesterol (TC). The effects of colesevelam on cardiovascular morbidity and mortality remain unknown.

In monotherapy dose ranging trials at doses of either 2.3g or 3.8g, colesevelam reduced LDL-C by 9-15% and TC by 4-7%; this is significantly less than that achieved with simvastatin, atorvastatin, pravastatin and rosuvastatin, but more comparable with the 17-19% reduction in LDL-C and the 12-13% TC reductions seen with ezetimibe. The greatest reduction in LDL-C and TC can be seen if colesevelam is used in combination with a statin; reductions of 42% for LDL-C and 28-29% for TC were reported when colesevelam was used in combination with simvastatin.

Trials suggest that colesevelam may be better tolerated than other BAS's, although monotherapy trials linked colesevelam to a possible increase in triglyceride levels. As with other BAS's, colesevelam should not be administered to patients who have high triglyceride levels; the manufacturer advises caution in patients with triglyceride levels greater than 3.4mmol/l.

PACEF Recommendation:
PACEF were concerned about the poor quality of the evidence reviewed in support of this product. The short-term underpowered nature of the trials, the lack of comparative data with other BAS's and the lack of outcomes data around cardiovascular morbidity and mortality were all disappointing. As a result of this, colesevelam was designated RED-RED. Where a BAS is indicated, for example, in those patients who are unable to tolerate treatment with statins and/or ezetimibe, a better established agent with cardiovascular outcomes data such as cholestyramine should be preferred.

RAPID ASSESSMENT

FOSTAIR (BECLOMETASONE AND FORMOTEROL) METERED DOSE INHALER

Fostair is a new CFC-free metered dose aerosol formulation containing beclometasone 100mcg and formoterol 6mcg per actuation. It is licensed as a regular treatment for asthma in adults who require a fixed dose combination of an inhaled steroid and long-acting beta$_2$ agonist (LABA) (e.g. those at Step 3 or 4 of the SIGN/BTS Asthma Guidelines).

It is important to note that Fostair is an 'extrafine particle' formulation; this means that the dosage of beclometasone delivered is equivalent to 2.5 times the dose of 'conventional' beclometasone. As a result of this, one puff of a Fostair inhaler can be considered to be equivalent to one puff of beclometasone from a 250mcg per actuation inhaler (the old Becloforte dose). The potency of formoterol does not appear to be altered by this microfine formulation.

Clinical trials have shown that 2 puffs twice daily of a Fostair inhaler are non-inferior to one dose twice daily of a Symbicort Turbohaler 400/12 and 2 puffs twice daily of a Seretide 125 (125mcg / 25mcg) MDI. A cost comparison between these three formulations reveals Fostair to be the lowest cost option.

Product	**Doses per inhaler**	**Unit cost**	**28 day cost**
Fostair inhaler 100/6	**120 doses**	**£29.32**	**£27.37 (2 puffs twice daily)**
Seretide 125 inhaler	120 dose	£36.65	£34.21 (2 puffs twice daily)
Symbicort Turbohaler 400/12	60 dose	£38.00	£35.47 (1 dose twice daily)

Similarly, Fostair is also the lowest cost option when compared to lower doses of approximately equivalent formulations:

Product	**Doses per inhaler**	**Unit cost**	**28 day cost**
Fostair inhaler 100/6	**120 doses**	**£29.32**	**£13.68 (1 puff twice daily)**
Seretide 50 inhaler	120 dose	£18.14	£16.93 (2 puffs twice daily)
Symbicort Turbohaler 200/6	120 dose	£38.00	£17.73 (1 dose twice daily)

Additionally, the Fostair MDI requires refrigeration throughout the supply chain and once dispensed is only stable for three months at room temperature. As a result of this, Fostair inhalers should usually be prescribed singly and patients should be advised to dispose of any remaining doses three months after dispensing. There is no requirement for the patient to refrigerate the MDI after receipt. Trinity Chiesi have assured us that these precautions will remain in place until further longer-term stability data becomes available.

PACEF Recommendation:
Fostair currently represents a lower cost inhaled corticosteroid/LABA combination inhaler than any of the alternative branded products at equivalent doses. However, the 'extrafine particle' formulation means that there is no

dose-for-dose equivalence between this product and other inhaled corticosteroid/ LABA formulations currently in use and transfer between one preparation and another could give rise to confusion. Additionally, the Fostair MDI is only stable for three months after dispensing. Despite these reservations, Fostair MDI is designated as GREEN. It should only be used for the management of asthma where a combination inhaler is appropriate. It is not licensed for the management of Chronic Obstructive Pulmonary Disease (COPD). For practices interested in using the device, it should be reserved for new patients only; it is not recommended for therapeutic switching due to the lack of dose equivalence with existing combination ICS/LABA inhalers.

FUTURE SUPPLY OF CFC CONTAINING BECLOMETASONE DIPROPIONATE METERED DOSE INHALERS (BDP MDIs)

There is currently a widespread belief across the NHS that chlorofluorocarbon-containing (CFC-containing) beclometasone dipropionate (BDP) metered dose inhalers (MDIs) are unlikely to remain available beyond Summer 2008. This has been picked up by news bulletins and various guidelines and advice is being given to prescribers on the best way to approach the transition against a tight timescale. We conducted a survey of all manufacturers of CFC containing BDP MDIs and found that the majority of current manufacturers and distributors have no plans to withdraw their products from the UK marketplace in the short to medium-term. However, we are also mindful of the fact that the *Drug Tariff* reimbursement price for CFC containing BDP MDIs is higher than branded CFC free equivalents and has risen further in the April 2008 *Tariff*. As a result of this, PACEF advice is as follows:

PACEF Recommendation:
The current price of generic CFC containing BDP MDIs in the *Drug Tariff* is higher than CFC free alternatives such as Clenil Modulite and has increased further in the April 2008 *Tariff.* For practices wishing to move away from CFC containing BDP MDIs (mindful of the fact that there is no urgency), Clenil Modulite, prescribed by brand, is advocated as the CFC free formulation of choice. New patients requiring a BDP MDI should be initiated on a CFC free product such as Clenil Modulite. Standardizing BDP MDI prescribing around a low cost branded CFC free product would also help to reduce prescribing costs.

PRODUCT DISCONTINUATION: COVERSYL AND COVERSYL PLUS

Servier have announced plans to discontinue Coversyl (perindopril tablets 2mg, 4mg and 8mg) and Coversyl Plus (perindopril 4mg/indapamide 1.25mg) and to replace them with new formulations containing the active salt, perindopril arginine. These new formulations will be known as Coversyl Arginine and Coversyl Arginine Plus. The claimed benefits are that this will standardize the manufacturing process of perindopril worldwide and extend the shelf-life of the product. Existing stocks of Coversyl and Coversyl Plus are likely to last no longer than eight weeks after the launch of the new formulation; Coversyl Arginine and Coversyl Arginine Plus will be available from April 1st 2008. The availability of generic perindopril tablets remains unaffected by this change.

PACEF Recommendation:
Prescribers are reminded that generic ramipril capsules and lisinopril tablets remain the ACEIs of first preference. All patients currently prescribed branded Coversyl or Coversyl Plus will need to be reviewed and their prescriptions

changed. Where perindopril is indicated, generic perindopril erbumine tablets should be prescribed. Generic prescribing of perindopril arginine or branded prescribing of Coversyl Arginine or Coversyl Arginine Plus is not recommended. For patients currently prescribed Coversyl Plus, it is recommended that generic perindopril erbumine plus an appropriate alternative diuretic should be prescribed. In the unlikely event that a patient needs to be transferred from perindopril erbumine to perindopril arginine or Coversyl Plus to Coversyl Arginine Plus, prescribers should be aware that these formulations are not dose equivalent: 2mg of perindopril erbumine equates to 2.5mg of perindopril arginine; 4mg to 5mg of perindopril arginine; and 8mg to 10mg of perindopril arginine.

SMOKING CESSATION AND VARENICLINE

Readers will remember from NICE Technology Appraisal 123 that NICE have endorsed the use of varenicline (Champix) within its licensed indications (smoking cessation in adults) as an option for smokers who have expressed a desire to quit smoking. Following the publication of this TA, PACEF recommended varenicline as a potential second line alternative to bupropion in patients committed to stopping smoking that have tried and failed to quit using NRT support. At the same time PACEF requested an assessment of the cost-effectiveness of varenicline based on real patient experience from the Phoenix Stop Smoking Service to be used to inform further guidance.

Recent figures provided by Phoenix compare four week quit rates for each of the major approaches to smoking cessation currently in use and reveal significantly higher quit rates with varenicline than for any other option:

	Cost	Phoenix Four Week Quit Rate (Apr- Sept 07)
National NHS Stop Smoking Services	£161	50%
Phoenix Stop Smoking Service	£160	49%
Varenicline	£164 full course	66%
Bupropion	£80 full course	51%
Nicotine Replacement Therapy (NRT)	£110 full course	46%

This correlates to some extent with some of the conclusions reached by NICE in TA 123. Specifically:

- Varenicline is superior to NRT and bupropion in achieving continuous abstinence.
- Varenicline represents a cost-effective use of NHS resources despite the fact that it is approximately twice the cost of alternative smoking cessation support therapies.

The results of a recent randomised trial comparing varenicline with NRT that was published in *Thorax* confirm higher abstinence rates at 52 weeks with varenicline than with NRT; the results, however, were not statistically significant and the higher cost of varenicline and higher incidence of side effects gave some cause for concern. Such evidence, applied in combination with current NICE advice, seems to suggest a role for all three pharmacotherapies in supporting stop smoking attempts and to

undermine the notion of a hierarchy of therapies in favour of a more patient focused selection of the most appropriate treatment for the individual.

Additionally, a recent Cochrane Review has compared the quit rate at one year of different levels of smoking cessation support:

Level of support	**Quit rate at 1 year**
Willpower and medicines alone	4-6%
Support and no medicines	10-15%
Support with medicines	20-30%

This illustrates the importance of an appropriate level of behavioural support being provided whenever any form of pharmacological smoking cessation support is prescribed. Phoenix have expressed concern that a significant number of potential quitters in Lincolnshire (possibly as many as four thousand a year) are prescribed pharmacological smoking cessation support from their GP but are not referred to the Phoenix Stop Smoking Service. If these patients are not being adequately supported during prescribed therapy, the chances of a successful quit are markedly reduced, regardless of the type of pharmacotherapy selected.

Some prescribers have been reluctant to prescribe varenicline in line with NICE TA 123 on the basis that varenicline is a 'black triangle drug' and there have been recent safety concerns reported in the media. The Medicines and Healthcare products Regulatory Agency (MHRA) recently issued a safety update on varenicline which discussed reports of suicidal thoughts and behaviour arising in association with the use of varenicline (*Drug Safety Update*, Vol 1, Issue 7 (February 2008)). Their general advice is as follows:

(1) Smoking cessation, with or without pharmacotherapy, may be associated with an exacerbation of underlying psychiatric illness, including depression. Care should be taken in such patients, who should be advised of this risk.
(2) Patients should be made aware of the possibility that trying to stop smoking might cause symptoms of depression.
(3) Patients who are taking varenicline who develop suicidal thoughts should stop their treatment and contact their doctor immediately.

In addition, NICE have recently published their Public Health Guidance on Smoking Cessation Services (PHG10 [February 2008]) and offer the following advice on pharmacotherapies:

- Three pharmacotherapies have been **proven** to help people stop smoking, NRT, varenicline and bupropion.
- **Pharmacotherapies work best when combined with support** such as that offered by an NHS Stop Smoking Service (e.g. Phoenix).
- NRT, varenicline or bupropion should normally be prescribed as part of an abstinent-contingent treatment, in which the smoker makes a commitment to stop smoking on or before a particular date (target stop date). **The prescription for NRT, varenicline or bupropion should be sufficient to last only until 2 weeks after the target stop date**. Normally this will be after 2 weeks of NRT and 3 to 4 weeks of varenicline and bupropion, to allow for different methods of administration and mode of action. Subsequent

prescriptions should be given only to those people who have demonstrated, on re-assessment that their quit attempt is continuing.

- **Varenicline or bupropion may be offered to people with unstable cardiovascular disorders**, subject to clinical judgement. (Bupropion can cause chest pain, tachycardia, hypertension: varenicline can cause chest pain, hypertension, tachycardia and atrial fibrillation).
- Combination therapy comprised of nicotine patches and another form of NRT (e.g. gum, inhalator, lozenge or nasal spray) may be used in people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past.
- When deciding which therapies to use and in which order, discuss the options with the client and take into account: (1) whether a first offer of referral to the NHS Stop Smoking Service has been made; (2) contraindications and the potential for adverse effects; (3) the client's personal preferences; (4) the availability of appropriate counselling or support; (5) the likelihood that the client will follow the course of treatment; (6) their previous experience of smoking cessation aids.
- Neither varenicline nor bupropion should be offered to young people under 18 nor to pregnant or breastfeeding women.
- **If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, do not offer a repeat prescription within 6 months unless special circumstances have hampered the person's initial attempt to stop smoking.**
- **Do not offer NRT, varenicline or bupropion in any combination.**
- Explain the risks and benefits of using NRT to young people aged 12 to 17, pregnant and breastfeeding women, and people who have unstable cardiovascular disorders. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use behavioural support in their quit attempt.
- **Practitioners should provide NRT and appropriate support to individuals who want to follow the nicotine assisted reduction to stop strategy (NARS) only if it is part of a properly designed and conducted research study.**

PACEF Recommendations:

Prescribers are reminded that varenicline is classified as GREEN. Recent supporting information from Phoenix endorses the NICE view that this agent can be considered as a potential alternative to NRT in appropriate patients. In order to maximise quit rates, pharmacological smoking cessation support in any form should be provided in conjunction with an appropriate level of behavioural support. Behavioural support is most readily available through Phoenix Stop Smoking Services and prescribers should refer potential quitters into this service wherever possible. At present, there is no evidence of a direct causative link between varenicline and suicidal thoughts and behaviour, although prescribers should remain vigilant to links between nicotine withdrawal, depression and exacerbation of underlying psychiatric illness. If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, do not offer a repeat prescription within 6 months unless circumstances are exceptional.

REVIEW OF BICALUTAMIDE TRAFFIC LIGHT CLASSIFICATION

Bicalutamide (Casodex) is an anti-androgen licensed for the treatment of:

- Advanced prostatic cancer in combination with a gonadorelin analogue or surgical castration.
- Locally advanced prostate cancer either alone or as adjuvant treatment.
- Locally advanced, non-metastatic prostate cancer when surgical castration or other medical intervention is inappropriate or unacceptable.

Recently, Lincolnshire based consultants have reported that a number of requests to GPs to initiate treatment with bicalutamide have been refused on the grounds that it was not felt to be an appropriate therapy to commence within a primary care setting. PACEF recently reviewed the use of bicalutamide within this context and reached the following conclusions:

PACEF Recommendations:
In 2003, the Committee on Safety of Medicines reviewed the risks and benefits of bicalutamide and concluded that the overall risk-benefit of bicalutamide in patients with locally advanced prostate cancer remains positive. No specific monitoring of bicalutamide is required, although the *BNF* advises periodic liver function tests. On the basis of this, PACEF have designated bicalutamide as AMBER. The drug is suitable for initiation in primary care within licensed indications on the advice of a specialist, usually provided in writing in the form of an out-patient letter. No shared care guideline is required.

NICE UPDATE

NICE TECHNOLOGY APPRAISAL 134: INFLIXIMAB FOR THE TREATMENT OF ADULTS WITH PSORIASIS (JANUARY 2008)

The key recommendations are as follows:

- Infliximab within its licensed indications (see below), is recommended as a treatment option for adults with plaque psoriasis only when the following criteria are met: (1) the disease is very severe as defined by a total Psoriasis Area Severity Index (PASI) of 20 or more **and** a Dermatology Life Quality Index (DLQI) of more than 18; (2) The psoriasis has failed to respond to standard systemic therapies such as ciclosporin, methotrexate **or** PUVA (psoralen and long-wave ultraviolet radiation) **or** the person is intolerant to or has a contraindication to these treatments.
- Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within 10 weeks. An adequate response is defined as either: (1) a 75% reduction in the PASI score from when treatment started (PASI 75) **or** (2) a 50% reduction in the PASI score (PASI 50) and a five-point reduction in DLQI from when treatment started.

Infliximab (Remicade) is licensed for the treatment of moderate to severe plaque psoriasis in adults whose condition has failed to respond to, who have a contra-indication to, or who are intolerant of other systemic therapies including ciclosporin, methotrexate or PUVA.

PACEF Recommendation:
Infliximab is designated as RED for the treatment of moderate to severe plaque psoriasis in adults whose condition has failed to respond to, who have a contra-indication to, or who are intolerant of other systemic therapies including ciclosporin, methotrexate or PUVA.

NICE TECHNOLOGY APPRAISAL 135: PEMETREXED FOR THE TREATMENT OF MALIGNANT PLEURAL MESOTHELIOMA (JANUARY 2008)

The key recommendations are as follows:

- Pemetrexed is recommended as a treatment option for malignant pleural mesothelioma only in people who have a World Health Organisation (WHO) performance status of 0 or 1, who are considered to have advanced disease and for whom surgical resection is inappropriate.
- Patients currently receiving pemetrexed outside of the criteria defined above should have the option to continue therapy until they or their clinicians consider it appropriate to stop.

PACEF Recommendation:
Pemetrexed is designated RED for the treatment of malignant pleural mesothelioma.

MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AGENCY (MHRA) SAFETY UPDATES

CARISOPRODOL AND MEPROBAMATE (FEBRUARY 2008)

Carisoprodol (Carisoma) is a centrally acting muscle relaxant used in the short term as an adjunct to the symptomatic treatment of acute musculoskeletal disorders associated with painful muscle spasm. Meprobamate is the active metabolite of carisoprodol and is used for short-term treatment of anxiety states or musculoskeletal disorders where, in either case, there is muscle tension or painful muscle spasm. **Marketing authorisation for carisoprodol is to be suspended, after a European review concluded that the risks of treatment outweigh the benefits.** Carisoprodol is associated with an increased risk of abuse, addiction, intoxication and psychomotor impairment. There are safer alternatives to carispodolol for the management of acute musculoskeletal disorders. A phased withdrawal of carisprodol from the UK market will take place. Meprobamate is closely related to carisoprodol and has a similar balance of risks and benefits. **The MHRA is exploring a phased withdrawal of meprobamate from the UK.**

The MHRA have issued the following advice to healthcare professionals currently prescribing carisoprodol and/or meprobamate:

- No new patients should be started on either carisoprodol or meprobamate.
- As carisoprodol is associated with a withdrawal syndrome and should not be stopped suddenly; a gradual decrease in dose is required (which may take several weeks for patients on high doses).
- If a withdrawal syndrome occurs, benzodiazepines are recommended in the short term: antipsychotics and antidepressants have also been used.
- Further advice on meprobamate will be provided by the MHRA in due course.

Analysis of local prescribing patterns has revealed very low use of both of these agents. Practices currently using carisoprolol have already been contacted by a PCT Prescribing Adviser.

ROSIGLITAZONE UPDATE

The European Committee for medicinal products for Human use has recommended new contraindications and warnings for rosiglitazone

- Rosiglitazone is now contraindicated in patients with acute coronary syndrome; rosiglitazone has not been studied in controlled trials in this group of patients.
- Rosiglitazone is also not recommended for use in patients with ischaemic heart disease or peripheral arterial disease, because of concerns about increased risk of myocardial infarction in these patients.

STATINS (JANUARY 2008)

The January 2008 MHRA update provided further advice on the most important and common interactions with simvastatin and atorvastatin. It included advice on potential interactions between atorvastatin and clarithromycin, itraconazole and ciclosporin as follows:

- **Itraconazole – do not exceed 40mg atorvastatin daily.**
- **Clarithromycin – do not exceed 20mg atorvastatin daily.**
- **Ciclosporin – do not exceed 10mg atorvastatin daily.**

This information has also been sent to all doctors in a letter issued from Pfizer dated 3rd December 2007. This letter also contained warnings of the increased risk of haemorrhagic stroke in patients treated with 80mg atorvastatin who have recently suffered a stroke. The findings come from a post hoc analysis of the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) study. The increased risk of stroke was particularly noted in patients with prior haemorrhagic stroke or lacunar infarct at study entry. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80mg is uncertain and the potential risk of haemorrhagic stroke should be considered carefully before initiating treatment.

AMENDMENT: NICE CLINICAL GUIDELINE 57: ATOPIC ECZEMA IN CHILDREN

PACEF recommendations on the prescribing of mild topical corticosteroids for atopic eczema in children are amended as follows

For mild topical corticosteroid preparations, the lowest acquisition cost products are: hydrocortisone (Efcortelan) cream and ointment 0.5% (30g, 61p), 1% (30g, 75p) and 2.5% ointment (30g, £1.70). Prescribing hydrocortisone cream or ointment generically as 15g packs can be expensive due to the high price of these packs; ideally 30g packs should be prescribed as Efcortelan.

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