Reducing Diclofenac Prescribing:
The success in Sheffield of joint working across the interface

Background

In October 2006, the Commission on Human Medicines (CHM) gave advice on the latest evidence for cardiovascular thrombotic risks of NSAIDs and advised that diclofenac 150 mg daily has a thrombotic risk profile similar to that of at least one coxib (etoricoxib) and possibly others.

Over the next 7 years, further evidence emerged that diclofenac is associated with cardiovascular risks that are higher than the other non-selective NSAIDs, and similar to the selective COX-2 inhibitors.

In July 2013 the MHRA issued a safety alert detailing new contra-indications and cautions for all systemic diclofenac preparations including those sold over the counter by pharmacists.

Diclofenac is now contra-indicated in patients with established:

- ischaemic heart disease
- peripheral arterial disease
- cerebrovascular disease
- congestive heart failure (New York Heart Association [NYHA] classification II–IV)

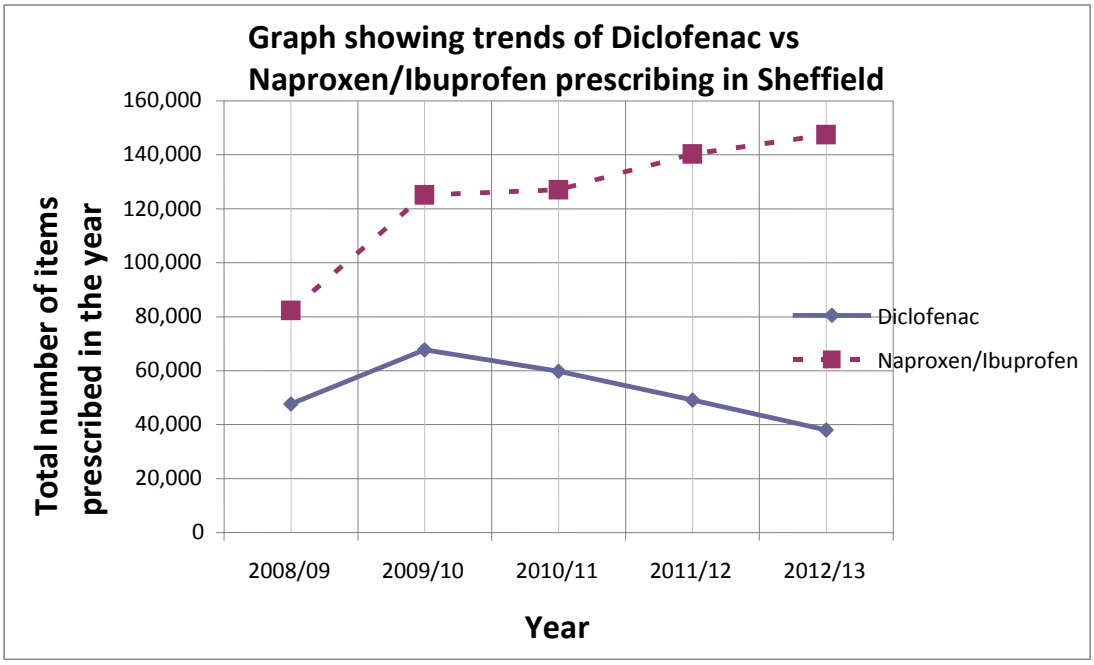
The MHRA has advised that patients with these conditions should be switched to an alternative treatment at their next routine appointment.

In addition, diclofenac treatment should only be initiated after careful consideration for patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking).

More information is available on the MHRA website here.

Actions taken in Sheffield

In Sheffield there have been initiatives in both primary and secondary care to reduce inappropriate diclofenac prescribing. The graph below shows the impact on primary care prescribing (data from ePACT).



Primary care

In primary care QOF audits were used as a way of highlighting to GPs the safety concerns with diclofenac.

- QOF 2008-09 offered a QOF audit "Diclofenac repeat prescription audit In line with guidance from MHRA Oct 2006".
- This was followed by the QOF audit in April 2010 "Diclofenac repeat prescription audit: managing cardiovascular and gastrointestinal risk in line with guidance from MHRA Oct 2006".
- QOF 2011-12 QP1-5 encouraged GP practices to improve the ratio of ibuprofen and naproxen compared with all NSAID items.
- In March 2013 diclofenac was removed from the Sheffield Formulary, because of its cardiovascular risks, and this information was highlighted to GPs via the ebulletin. The oral NSAIDs of choice in Sheffield are low dose ibuprofen or naproxen.

Secondary care

In June 2013, STHFT changed from using diclofenac 1st line to using low dose ibuprofen or naproxen for initiation of a NSAID. Trust wide guidelines were produced, and after an extensive awareness campaign, ward stock was switched to encourage compliance with the new guidelines.

Following the safety alert in July 2013, patients admitted to STHFT on diclofenac with contra-indications are being switched to either ibuprofen or naproxen. The GP will be informed via the discharge summary and the patient issued with the patient information sheet provided by the MHRA. They will be advised to visit their GP if the alternative NSAID does not control their pain adequately. Patients admitted on diclofenac with the significant risk factors detailed by the MHRA (but not contraindications), will be left for review by the GP.

Chief Pharmacist at Sheffield Children's Hospital, David Upton has confirmed that SCH will continue to use diclofenac since the cardiovascular risks are not evident in paediatrics and they are limited as to what licensed NSAID they can use in this group of patients.

Successful results

Prior to the switch at STHFT, diclofenac accounted for 68% of named patient hospital supplies of oral NSAIDs. This has been reduced to 5%, with 84% patients now receiving ibuprofen and the remaining 11% receiving naproxen (10%) or indometacin (1%).

The reduction in primary care prescribing is shown in the graph on page 1. The ePACT data shows the ratio of diclofenac compared with naproxen/ibuprofen has been reduced from 49.8% in 2008/09 to 27.6% in 2012/13. The secondary care change is not yet reflected in ePACT data so it is likely this ratio will continue to improve.

Conclusion

Working together to tackle an important patient safety issue has resulted in a reduction in diclofenac prescribing across the city. This joint working across the interface to improve patient safety has succeeded due to a high level of collaboration between primary and secondary care.

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