North Yorkshire and York
Humber and North Yorkshire
Health and Care Partnership

NHS
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North Yorkshire
Integrated Care Board (ICB)

FAO: Primary Care Colleagues in North Yorkshire and York places

Medicines Management Prescribing Focus – October 2022

Revisiting Dosulepin, Co-proxamol and Trimipramine Prescribing

Dosulepin

Practices will be aware that there have been multiple safety warnings regarding dosulepin prescribing over the last few decades. In 2007 the MHRA advised that, as dosulepin has a narrow safety margin, it should be avoided. NICE stated in their 2009 clinical guideline on depression (CG90 - since updated) that dosulepin should not be prescribed. In 2017 NHSE included dosulepin in their guidance "Items which should not routinely be prescribed in primary care" because of these safety concerns. It is also noted in the BNF that dosulepin is not recommended due to an increased risk of fatality in overdose.

Locally, the North Yorkshire and York area prescribing committee (APC) does not support the prescribing of dosulepin for any indication and issued a position statement in May 2022 to aid prescribers in their discussions with patients on this subject. TEWV have also issued helpful dosulepin deprescribing guidance which may be found here.

Summary of Actions Required

- Dosulepin poses a significant risk to patients and the MMT is asking prescribers to actively review all patients still prescribed this medicine and renew efforts to switch to an alternative and safer antidepressant.
- Patients at risk of suicide should be reviewed as a matter of urgency.
- At each medication review, consideration should be given to reducing the dose, with a view to changing to an alternative, or stopping treatment.
- If prescribing of dosulepin is to continue, thorough documentation is required in the patient's clinical record at the time of the consultation with the patient and again at every subsequent medication review, to clearly describe the reason for not stopping this high-risk medicine.

Co-proxamol

Similarly, there have been multiple safety warnings regarding the prescribing of co-proxamol, in this case starting as long ago as 1985.

Co-proxamol was withdrawn from the market in 2007 on the advice of the MHRA due to serious safety concerns. The MHRA has estimated that the withdrawal of co-proxamol from the UK has saved around 300–400 lives each year from self-poisoning, around a fifth of which were accidental.

In 2017 NHSE included co-proxamol in their guidance "Items which should not routinely be prescribed in primary care" because of these safety issues. It is also noted in the BNF that co-proxamol is not recommended because of safety concerns, particularly toxicity in overdose.

Co-proxamol is now only available as an unlicensed medicine obtained from specific suppliers, which incurs variable and significantly higher costs when compared to other analgesic preparations.

Locally, the North Yorkshire and York APC does not support the prescribing of co-proxamol and issued a position statement (under the heading 'Pain') in 2021 to aid prescribers in their discussions with patients on this subject. PrescQIPP have also issued a helpful patient information leaflet, which may be found here.

Summary of Actions Required

- Co-proxamol poses a significant risk to patients and the MMT is asking prescribers to actively review all patients still prescribed this medicine and renew efforts to switch to an alternative and safer analgesic medicine.
- Patients at risk of suicide and those who are alcohol-dependent, or who are likely to consume alcohol whilst taking co-proxamol, should be reviewed as a matter of urgency.
- At every medication review, consideration should be given to changing to an alternative.
- If the prescribing of co-proxamol is to continue, thorough documentation is required in the patient's clinical record at the time of the consultation with the patient and again at every subsequent medication review, to clearly describe the reason for not stopping this high-risk medicine.

Trimipramine

Although less high profile than the safety issues for dosulepin or co-proxamol, trimipramine is also known to be more toxic in overdose than alternative options. In their deprescribing guidance, TEWV state that less than 3 weeks' supply is likely to cause serious toxicity or death. Trimipramine is also included in the NHSE guidance "Items which should not routinely be prescribed in primary care" partly due to these safety concerns and also its higher cost when compared to other antidepressant preparations.

Summary of Actions Required

- Do not initiate trimipramine in any new patients.
- Review all existing patients prescribed trimipramine and deprescribe where appropriate:
    - Switch to an alternative antidepressant, if patients are under the care of a specialist, involve them in the decision to discontinue or switch treatment.
    - As with all switches, this should be tailored to the individual patient.
    - Patients at risk of suicide should be reviewed as a matter of urgency.

Please review the prescribing data for your practice – attached separately.

We would like to take this opportunity to remind all staff involved in making alterations to medication that patients should be informed of any change. Ideally, this should be done face to face, by telephone or by letter. Alternative methods of communication may be considered but must be unambiguous.

Please share the information in this document with all relevant members of staff in the Practice.

For any queries or feedback on this month's prescribing focus please contact the respective teams via: nyccg.rxline@nhs.net (North Yorkshire) or hnyicb-voy.rxline@nhs.net (York).

The MMT welcomes further ideas and suggestions that you and colleagues may wish to recommend for future prescribing focus editions.

Many thanks,

North Yorkshire and York Medicines Management Team